MENTAL HYGIENE

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THE RELATIONSHIP OF PSYCHIATRY TO INTERNAL MEDICINE*

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THE problem that confronts the internist and the general practitioner is quite different from the problem that confronts the specialist. The specialist lays claim to a superior and more detailed knowledge of one field of medicine, and his opinion in this field is supposed to be authoritative. When a patient consults him, he must answer, first, the question whether or not the patient really has a disorder of the particular system in which he is interested, and if the decision is that he has, must determine, second, the nature and extent of the disorder. In coming to these conclusions, the specialist must very astutely consider the possible operation of nervous or functional causes, well knowing how often such causes produce symptoms that simulate organic disease. Nevertheless, the character of his service is such that he does not feel called upon to investigate further into the origin of functional symptoms, nor indeed is he expected to do so. With the definite decision that the symptoms are functional, his contribution to the situation comes to an end.

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The internist, on the other hand, offers breadth of medical knowledge as a counterbalance to lack of depth. Every patient who comes to him is ill, and it is his function to determine, not that this organ or that is healthy or diseased, but how and why the patient is ill. Could we get a satisfactory insight into the operation of a human being as a whole by a separate detailed study of each organ or system, the problems of diagnosis and treatment would be simple indeed. The facts of such detailed study we must have, and in difficult and uncertain situations we call upon special skill and knowledge for assistance in gathering them, but once in possession of these facts, the internist must weld them together to reproduce the picture of a sick human being. The results of such a mental synthesis of the data obtained by careful analytical study are so complicated that each instance of disease stands out as a unique experience, the exact like of which has never occurred before and will never occur again.

These distinctions I point out briefly because it is important to bear them in mind in considering the relationship of psychiatry to medicine. To the specialist, psychiatry is another specialty, operating in a contiguous, but separate domain. To the internist, it is a vital and integral part of his work. Indeed I find it impossible to formulate a clear expression of the relationship of psychiatry to medicine, so intimately and inextricably are they bound together. The physician studies and practices psychiatry continuously, even when he protests that he has not the least knowledge of formal psychiatry. It is the chief instrument of his success, even though he may practice it unconsciously. Psychiatry is a discipline whose purpose it is to study and understand the function and influence of mental processes and emotional states in health and in disease. These dominate our life and influence every other function of the body, as in turn they are influenced by every other function. Until recently they have been studied only when they have led to grossly disordered conduct. Now they are being fruitfully studied as they operate under normal conditions, and knowledge of their sphere of activity in illness is rapidly extending. In spite of the growing importance of this subject, it is the

one about which medical students know least and the one in which their training is most deficient. The reasons for this slighting treatment of psychiatry are many; I can notice only a few of the outstanding ones.

1. *The general lack of appreciation of the importance of the subject.* When I was a medical student, psychoneurotics were objects of ridicule and contumely, not of serious study and sympathy. The patient with no gross lesion to justify his many complaints was neglected and avoided. The worst insult that could be cast at a fellow student was to call him a neurasthenic. After careful observation had established the fact that a patient had no organic disease, professional relations were supposed to be at an end, and he was dismissed with some such reassuring remark as, "There is nothing whatsoever wrong with you. Your troubles are imaginary. Go on and forget them," or even more curtly with a placebo and the ardent hope that he would never return.

With the passage of years this brusque attitude has become somewhat softened and yet essentially it is still the attitude of many physicians. The mind always seeks precise classification and is never more pleased than when experience can be snugly labeled. Packing it away in this neat fashion is so much more satisfactory than delving about for explanations that require long and painstaking investigation and may in the end elude our search. The great number of elaborate tests now available for diagnosis plays smoothly into this indolent habit of mind. Surely one of them will sooner or later reveal some abnormality, and upon this slender thread of evidence the patient's symptoms conveniently may be strung.

As an example, a man complains of discomfort in the chest and palpitation of the heart; he fears he may have some grave disorder of that organ. The examination reveals nothing abnormal; but an electrocardiogram must be taken, and this shows some slight deviation from the average form of the curves. This deviation, although it may be of questionable significance, is seized upon as convincing evidence of myocardial disease. The patient's worst fears are confirmed, and the doctor is happy that his up-to-dateness has

permitted him to make such a penetrating diagnosis. It often happens, under these circumstances, that a little patient inquiry and a sensible appraisal of all the evidence clearly establish the fact that the heart is sound and the man suffering from anxiety neurosis.

Again, a tall, lanky woman complains of indigestion. The roentgenological examination demonstrates that the stomach and colon occupy a low position in the abdomen. In spite of the fact that under the circumstances they should, and must of necessity, occupy a low position, this physiological variation is labeled enteroptosis, as if it were a disease, whereas often enough the suffering woman is struggling under a burden of unhappy conditions at home which well might turn the strongest stomach.

2. *The time required to ascertain psychiatric facts and the exhausting nature of the treatment of psychoneurotic patients.* It takes little time and is no tax at all upon the mind to order numerous tests and swiftly tabulate the morbid conditions they reveal; whereas it requires great patience and much serious thought to gather the particulars of a patient's constitution and environment and to assemble these data into a background for the illness. The busy practitioner, seeing twenty or thirty patients a day, cannot afford the necessary time, and as a rule the consultant is preoccupied with the search for recondite lesions. Every physician who interests himself, even if only a little, in these matters, is well aware of the trying and exhausting nature of the diagnosis and treatment of psychoneurotics. Even the professional mind has great difficulty in grasping clearly the interrelationship of mental and emotional states with functional disturbance in remote organs. To the lay mind such a relationship seems to contradict all firmly established habits of thought, and the imputation that it does exist usually is regarded as ridiculous or insulting. Endless patience and repeated exposition are necessary before the tentative acceptance of such a bizarre idea can be won. Then the physician must instill courage and lend support during the harassing period of readjustment and invent absorbing interests and occupations to fill the days with pleasant stimulation. Moreover, this rational plan of treatment is suited only to intelligent patients. The stupid

cannot profit from it and must be managed in a different way. That physicians manage badly is fully demonstrated by the many therapeutic fads and cults we see prospering all about us.

A short time ago I invited a young physician to look after a patient who was suffering from mild depression and anxiety. Although he was still young, a natural aptitude and unusual experience had combined to make him successful in the handling of such situations. He very courteously replied that he would gladly do whatever I asked of him, but good-naturedly begged me not to think of him only in connection with psychiatric problems. He went on to explain that he was alarmed by a growing reputation in this field. At that time he already had five similar cases under his care, and after having spent an hour or more with each patient the day was gone, he was completely exhausted, and the financial reward was relatively slight. Moreover, his interests were chiefly in medicine, and he rightly feared that his practice might be diverted to psychiatry.

3. *The subject matter and the material selected for psychiatric teaching and demonstration.* When I was a student, the course in psychiatry consisted of lectures upon insanity and the demonstration of patients with gross disorders of thought and conduct. I had no interest in the topics and the patients distressed and disturbed me. I was greatly relieved when the course was over and never dreamed that I should find any occasion upon which to apply what I had heard and seen. I fully determined to have nothing further to do with psychiatry and unfortunately I held very obstinately to this determination. As a matter of fact, I still hold to it as regards what I then considered to be the province of psychiatry. I say that this determination was unfortunate because it prevented me from understanding what is the true domain of psychiatry, and so blinded me that it was many years before I could see the fruitful application of psychiatry to the daily problems of practice. In a word, the practicing physician is not at all interested in what he scornfully regards as the medicine of the madhouse and the asylum; but he is vitally interested in what we may call everyday psychiatry. At least he becomes interested in it

when his interest is properly aroused by the demonstration of the importance and value of the application of psychiatry to his daily work. He must know a little about gross disorders of the mind, but only enough to see clearly that these extreme alterations are merely exaggerations of trends and reactions that he may observe in himself, in his friends, in his patients. If a physician is once persuaded to look within himself and to learn to identify unaccountable variations in mood and energy as the analogue of a manic-depressive cycle, the habit of ascribing failure and disappointment to ill luck or persecution as the promptings of paranoia, daydreams (in which satisfaction is secured for the rubs and indignities of life and retributive disaster showered upon enemies) as the harmless whisperings of schizophrenia, certain exaggerated reactions as the masks for defects and inadequacies, various somatic symptoms as excuses for retreat from difficult or unpleasant situations, he will forever after have an enduring interest in psychiatry.

I repeat, the physician's interest in psychiatry is limited to its application to the large number of patients usually referred to as psychoneurotics, and the broadest and most useful field for psychiatry is to teach physicians to understand the difficulties of these patients and how best to treat them. Until recently the psychiatrist has avoided this responsibility and missed his opportunity. The fault is only partly his, however, for the greater part of the blame rests upon the physician, and upon the distance that has separated the physician from the psychiatrist. Even to-day most psychiatrists reside or work at institutions far removed from the general hospital. It is inconvenient and time-consuming to call them in consultation to the medical wards; therefore, they are called but seldom, usually only when there is a question of transferring a patient to their care. Under the circumstances, an intimate association between psychiatrist and internist is out of the question. When one considers the many occasions upon which they may be mutually helpful, this separation is indeed deplorable. It is a pressing problem to devise ways in which a free-and-easy intercourse between physician and psychiatrist may be established.

It is only within the past decade that psychiatrists have become familiar figures upon the medical wards of hospitals fortunate enough to have psychiatric divisions as a part of their facilities. This familiarity is a spectacle for rejoicing, for the psychiatrist is badly in need of expert medical advice in managing his patients, and the physician is even more in need of skilled psychiatric aid. A cordial relationship between the medical and the psychiatric departments is particularly desirable in teaching hospitals. If psychiatrists sincerely wish to interest students and to impress upon them the growing importance of psychiatry in practice, they must select illustrative cases chiefly from the medical wards and the out-patient departments. There are met the problems that are the very stuff of daily practice, and there must the demonstration be made that psychiatric knowledge is a vital and helpful force in understanding and treating sick human beings.

4. *The difficulty of teaching the methods of psychiatric examination and interpretation.* The revelations of a psychiatric examination are to the last degree confidential. It would be impossible for a patient to lay bare his heart before an audience. A student may not even practice psychiatric methods under the guidance of a tutor. After preliminary instruction, he must retire with the patient alone and gather such facts as he may be able to uncover. Later he may have the opportunity to compare his yield with what is accumulated by the psychiatrist on another occasion. This method of teaching is laborious and time-consuming. Medical demonstrations may be made before large groups of students, and in smaller groups the students may verify the observations made by the instructor. It is true that grossly disordered psychiatric patients may be demonstrated in the same way, but I have taken pains to point out that this aspect of psychiatry is of secondary interest and importance to physicians. Perhaps at present most can be accomplished by physicians themselves constantly calling the attention of students to the importance of psychiatric problems in the patients under their care, and by stimulating and encouraging them to consider and to examine into this aspect of disease.

Many physicians are held aloof from psychiatry by the erroneous impressions that psychiatric methods of examination are difficult to master, that psychiatric concepts are recondite and forbidding, that psychiatric practice is almost entirely a preoccupation with sex, and that the special aim of psychoanalysis is the sole aim of psychiatric treatment.

Physicians and students need to be told again and again that the methods of psychiatry are very simple and easy to learn. All that is required is a sympathetic interest in human relations and reactions. Prompted by this interest, every intelligent physician will soon know from experience what to search for and how to conduct the search. Nine out of ten psychiatric problems are superficial and explain themselves, if the physician gains the confidence of the patient and merely encourages him to talk freely about himself and his difficulties. A question interposed now and then is all that is necessary to guide the revelations into desired and fruitful channels. Only occasionally is a more searching and deeply probing investigation necessary, and when this is required, the psychiatrist must be called upon for aid. It is not a matter of wonder that the trained psychiatrist can get the desired information more quickly and more fully than the physician. It would be remarkable were he not able to do so, for this is his particular affair, in the conduct of which he has special skill and training. Nevertheless, it is entirely superfluous to burden him with the investigation of every trite situational reaction that confronts the physician. The matter is precisely as it is in other fields of practice. It is not to be supposed that every physician is versed in the intricacies of electrocardiography, and yet it would be folly to contend that because he lacks this special knowledge, he is incompetent to treat any case of heart disease.

Every special field of knowledge soon develops its own particular terminology; new and unfamiliar words are coined and new meanings become attached to old words. To workers in the field, this terminology is a convenience, even when it serves no other useful purpose; but to the uninitiated, it is a serious and confusing barrier. I do not mean to imply that psychiatrists offend more than others in this respect,

for it is a universal custom, but I will say that they offend as much as others, and I deeply regret the offense, since its habitual practice is mainly responsible for alienating the interest and support of physicians. I can think of no better way to teach psychiatry than to insist, as many psychiatric departments now do, upon the student's writing out an analysis of his own personality. For this purpose he is furnished a pamphlet containing questions to be answered, with directions and explanations. Recently a puzzled student asked me to go over such a form with him, and I was much embarrassed at being obliged to confess that parts of it I did not understand. I wish I could persuade the psychiatrists to unbend their diction before the simplicity and innocence of physicians. It would go a long way toward arousing and cementing professional friendship.

No thoughtful person will question the profound influence of the sexual instinct upon every ramification of life, and yet it is by no means the only source of all the misery, suffering, and frustrations that afflict us. It is curious that physicians as well as the laity have seized upon this facet as the insignia of psychiatry. The imputation is undeserved. I can testify from my almost daily association with psychiatrists that their professional thought and practice do not revolve solely through this lubricous orbit. No doubt at times the errancy of the instinct must be thoroughly examined and investigated, but such occasions are rare in the ordinary routine of practice.

It is not my task to appraise the value of psychoanalysis as a method of psychiatric treatment. In the general psychiatric plan of prevention and cure, it occupies an insignificant, almost a negligible rôle. As a matter of fact, its applicability is hemmed in by many restricting circumstances, and no matter how successful it might prove to be, it could never be extended to include more than a few favored patients. By the practicing physician, psychoanalysis may be entirely disregarded, for at its best it is an ultra-refined technique suitable for use only on rare occasions. It is unfortunate that many physicians identify the special aims and methods of psychoanalysis with the general aims and

methods of psychiatry, and under this misconception speak of the whole field of psychiatry with ridicule and contempt.

In order to furnish tangible evidence of the important part psychiatric problems play in the practice of medicine, I have reviewed the records of five hundred consecutive patients who consulted me. To give the figures any value, I must explain that my practice covers the whole field of internal medicine, and that patients come to me or are sent to me chiefly for diagnosis. I have no reputation as a psychiatrist nor am I even suspected of having unusual interest or talent in that field. Not one of the five hundred patients consulted me on account of an overt psychiatric condition. Of the 500 patients, 272 were males, 228 females. The age incidence was as follows: first decade, 7; second decade, 28; third decade, 56; fourth decade, 93; fifth decade, 138; sixth decade, 109; seventh decade, 58; eighth decade, 11. Sixty-eight per cent of the patients were in the age span from thirty to sixty, the time of life during which functional disorders are especially prevalent.

Among the 500 patients there were 116, or 23 per cent, without any discoverable organic cause for the symptoms of which they complained. In addition, there were 56, or 11 per cent, who presented minor organic lesions, but whose symptoms could not possibly be explained by the lesions alone. In a word, one-third of the patients suffered solely or predominantly from functional disorders.

Strictly speaking, it might be stretching the point to say that all of these functional disturbances were due primarily to psychiatric disorders. Nevertheless, if you are willing to define the province of psychiatry as the broad field I have outlined, then surely the problems of these patients are of interest and concern to psychiatrists. For instance, a man otherwise well and competent suffers from very distressing digestive symptoms whenever he is worried or for other reasons is under nervous strain. Shall we consider this a psychiatric problem? I think we undoubtedly must, since here psychic influences play the chief rôle in disturbing the balance of the vegetative nervous system. What is commonly called the spastic colon invades the psychiatric field more prominently than it does the gastroenterological.

There is greater difficulty and uncertainty of classification in psychiatry than in any other department of medicine. Each patient presents an individual problem and in most instances only with violence can they be squeezed into precise categories. It is for this reason that we use such a broad and indefinite diagnosis as psychoneurosis. I do not pretend to give more than a hint as to the nature of the material that has come under my observation by listing the diagnoses. Still, every physician, from his own experience, will at once understand what is meant. The 116 cases to which I have referred were classified as follows:

Psychoneurosis	57
Anxiety neurosis	14
Functional digestive disturbances	14
Exhaustion syndrome	11
Mild depression	9
Cardiac neurosis	5
Constitutional inferiority	3
Hysteria	1
Anorexia nervosa	1
Schizophrenia	1

Since half of the patients are grouped under the caption *psychoneurosis*, I add a brief word of explanation. Many of these patients presented simple situational reactions, some of them superficial and almost obvious. Others were illustrations of inadequacy in the matter of meeting and overcoming the ordinary difficulties of life; and still others were examples of a flight into invalidism to escape more pressing demands which seemed insurmountable. Nevertheless, all of them were sent or came for examination because they complained of somatic symptoms, and many were regarded as uncertain or puzzling problems in diagnosis. I choose at random illustrative cases.

Here is a young woman of thirty-six with complaints of indigestion, pain in the joints, fatigue, and exhaustion. Her married life has been unhappy and she has recently got a divorce. She has returned to her family, but it is necessary that she do something to help support herself. She is ill prepared to meet this necessity, and for a year has searched about unsuccessfully for something that she may do. She is discouraged, disappointed, and unhappy.

Here is a man of fifty-eight complaining of heart trouble. Six years ago, after months of intense nervous strain, he became increasingly con-

scious of discomfort and aching about his heart. A number of physicians assured him that there was nothing wrong with his heart, until at last one took an electrocardiogram and solemnly made him promise that for three months he would never walk more than two blocks on the level nor climb a flight of stairs, except under neccessity and then only with extreme caution. From that day on he was a hopeless invalid, and no subsequent reassurance could win back his confidence, in spite of the fact that the most searching investigation failed to reveal the slightest abnormality.

Here is a frail young woman of twenty-three who has lost appetite, has constant abdominal discomfort, is utterly exhausted, and has withdrawn more and more from her friends and accustomed activities. Investigation demonstrates conclusively that this is a mild depression.

Here is a man, forty-five years of age, miserable with gas, abdominal distension, and discomfort after eating. Ulcer is suspected. He has been under a heavy burden of responsibility and worry, working day and night. He has fallen into the unfortunate habit of swallowing air.

Here is another man of thirty-nine, sent for examination by his employer, who writes that the patient is one of his most capable assistants, but has become almost useless because illness keeps him away from work nearly half the time. The cause of the disability is supposed to be sinus trouble and recurring respiratory infections. Examination fails to reveal any disease of the respiratory tract or of the other organs. Further investigation discloses unsuspected mental inadequacies hidden behind a jovial and cordial exterior. In boyhood he stammered and was so sensitive that to recite in class was a torture. His last year at college he purposely fell back in his work, for had he done his best, he would have finished at the head of his class, and would have been required to give the commencement address. Death was preferable to facing this ordeal. Although later he overcame stammering, his life was daily filled with embarrassment, reticence, and timidity. Unfortunate conditions at home gave him no repose or comfort there.

It is clear from this brief summary that at least one quarter of all the problems with which the physician deals are essentially psychiatric problems. Therefore, it cannot be emphasized too often or too strongly that he should be familiar with the nature of these problems, alert to detect their presence, and reasonably skillful in their management. Neglect of these essentials leads to useless and sometimes harmful treatment, to unnecessary operations, to confirming patients in assured invalidism.

It is the fashion now to preach these truths to the doctor and to take him to task for their neglect. I do not deny that the lesson has been deserved. Nevertheless, I wish to

point out a real danger to one-sided overemphasis. The most crushing disgrace a doctor can suffer is mistakenly to treat a patient with organic disease under the assumption that his disorder is due entirely to functional causes. Nervous or psychiatric patients often have organic diseases and to overlook them is fully as disastrous as to mistake functional disorder for organic disease. It must be remembered that the distinction between organic and functional disease is always difficult and sometimes calls for the very highest skill of the physician. Merely to emphasize the importance of being alert to the significance of mild psychiatric disorders will help little toward their recognition. The remedy, here as in other fields of medicine, is not propaganda, but a higher level of general medical skill and knowledge.

MENTAL HYGIENE IN A GENERAL HOSPITAL *

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THE patient referred to a general hospital is usually suffering from a more or less obscure or serious illness, and few patients are able to face such a situation without personality changes. These changes may be temporary, but frequently they are permanent. Many factors are operative in such cases. The average patient is more fearful of invalidism than of death. Loss of income in the case of the wage-earner or increased expense in connection with the absence from the home of the housewife are factors that are important even in normal times, and the condition that brings the patient to the hospital usually involves an indefinite period of lost time or a certain degree of permanent disability. The physician can seldom make a definite prediction as to this. The costs of hospital service, and they are necessarily high, does not improve the situation.

The financial insecurity that has prevailed since 1929 has focused attention on these problems. Patients have been more frank in their discussion of their difficulties. Fear of losing one's job through illness or of being rejected on reëxamination for employment has been a factor of more than ordinary import. It has become increasingly apparent that patients admitted to hospitals for physical disease have worries, fears, and even more serious mental difficulties which materially influence their progress toward recovery. An increasing number are admitted with symptoms that simulate those of serious organic diseases, but that prove to be functional and to have originated from emotional or similar disturbances. This group have been most prominent in the out-patient departments, but a large number of them have required ward service.

* Read at a meeting of the Buffalo Mental Hygiene Society, May 6, 1938.

The medical profession was not too well prepared for this rather sudden emphasis on the functional or mental aspect of illness. The modern hospital shares some of the responsibility for the trend, evident in past years, toward treatment of the disease that brings the patient to the hospital and relative neglect of the individual who comes to the hospital. The medical profession has been busy assimilating a rapidly increasing mass of scientific data which have to do with diseases rather than with patients. The hospital has been ready to play an increasingly important part in the management of serious illness. The staff undertakes much of the detail of management that formerly was a personal service from the physician. And the physician has, in consequence, assumed a less personal interest in and relationship toward his patient and has concentrated his attention on the more scientific aspects of the disease. Under these circumstances the worries, fears, and more serious mental difficulties of the patient are easily overlooked. He has continued to look to his physician for assistance, but as a rule he is reticent about mentioning these very personal subjects before the usual group that visits him on "rounds." Occasionally a bolder patient will call his physician back in an attempt at a more personal contact, but this frequently does not achieve the purpose, and those most in need of help are the ones who will not make such an attempt.

It has become increasingly evident that this problem requires more consideration. Thoughtful physicians are realizing that the vital thing that is being lost from the patient-physician relationship is the discussion of these mental difficulties. The reason for the failure of the pure scientist to obtain the good functional results, in the way of recovery, that are obtained by his less scientific, but more human neighbor lies in his neglect of these mental factors, which are operating unknown to him. These failures occur at times in spite of excellent anatomical results. Speaking as a physician, I believe that the patient will not be entirely satisfied until the physician assumes as much responsibility for his mental problems as for his physical. From the standpoint of the hospital, it will be more satisfactory for the physician to assume his former rôle and to include in the management

of the patient a consideration of the mental as well as the physical difficulties that arise.

There seems little doubt that the hospital will have to take some responsibility. The physician can reasonably expect as much assistance from the hospital in the management of these mental problems as he already receives in the case of the physical problems. The hospital already has the usual employer's responsibility in the way of selection of employees with good mental health. It must also take precautions to see that this healthy mental state is maintained. This is of more than ordinary importance because the hospital employee is in constant contact with a public under strain. Difficulties seem more apt to arise with relatives and in some instances friends than with the patient. The importance of tactfully securing the coöperation of the family in following hospital procedures and regulations cannot be overemphasized. Certainly a staff that has not established a friendly contact with the patient and his family cannot be of much assistance to the physician in solving mental problems. A coldly impersonal contact will secure little information of value in this very personal field.

If the hospital is to undertake more of the needed study and correction of the emotional and mental conflicts of the patient, careful attention to the training of personnel will be necessary. The development of an active teaching neuropsychiatric department will be necessary. This department cannot be expected to undertake the management of all the problems that arise. They will have to continue to accept the problems that are more complicated from the preventive standpoint and to treat the more definite mental diseases which require expert psychiatric treatment. The increasing volume of cases referred to a good department will prevent them from undertaking more than this. The necessity for an active teaching program in this department is obvious, and this program should not be confined within the department. Many members of the hospital staff are young and have no real personal knowledge of the emotional and mental conflicts that confront their patients. Their case studies reveal little or no appreciation of this side of the patient, and too often their attitude is one of complete indifference toward it.

The instruction in mental hygiene and preventive psychiatry in medical-nursing schools should be continued in post-graduate years. Similar instruction should be included in courses given to the other technical assistants who meet the patient and his relatives. The importance of the mental aspect of physical disease should be emphasized and simple techniques of treatment should be taught.

The care of the aged is an increasingly important problem for the hospital. Physicians should hesitate to hospitalize these patients unless it is absolutely necessary. In spite of this, an increasing number of them will continue to come to hospitals for a variety of physical diseases. These conditions cannot be treated by the psychiatrist, yet the effects of the change in environment from the home to the hospital are frequently disastrous for these patients. The mental deterioration that can occur in a few days is remarkable. The importance of a friendly understanding of their mental confusion and of an active effort to assist them in achieving an adjustment should be made apparent to every member of the staff. A maximum degree of both mental and physical activity should be insisted upon.

The frequency of mental changes in patients with serious physical defects has long been recognized, but too little attention has been paid to the effect on the patient of the knowledge that he has a serious disease of the kidneys, the lungs, or that vital organ, the heart. The necessity of physical rest has been emphasized, but the equal importance of mental rest is too often overlooked. A brief discussion of the worries of the patient about his future and an explanation of the simple facts concerning heart failure will do much to allay his fears and at the same time secure his intelligent, active coöperation in the prevention of subsequent periods of failure. This must be considered mental hygiene of a most practical type, and it will continue to come most effectively from the physician who is responsible for the treatment of the patient's heart disease rather than from a relative stranger.

Another group of conditions to be considered is that in which there is a background of neuromuscular dysfunction particularly related to a smooth or involuntary muscle.

Important members of this group are bronchial asthma, functional gastrointestinal disease, and hypertension. Excessive muscle tension or spasm of the smooth muscle of bronchial, gastrointestinal, or vascular bed, is to be considered of importance in the causation of these conditions. Numerically they are becoming an increasingly important group, and they are responsible for much ill health and disability. There are few of these patients who do not have a background of emotional or anxiety disturbances. It is a common experience to find that the hypertensive blood pressure varies within a wide range and that home conditions are responsible for these variations. These mental disturbances may not be and usually are not the only factors involved, but a careful evaluation of their importance is always necessary. To explain the importance of avoiding these disturbances is frequently the most helpful thing the physician can do for these patients. If such conditions are not corrected early, serious organic complications may occur as a result of the functional disturbances. The importance of good mental hygiene for individuals suffering from this type of disease cannot be overemphasized.

Another type of condition is the more purely psychiatric problem. The psychoneuroses are the outstanding example of this group so far as numbers are concerned. They are to be found in every service of the ward or dispensary. They seldom reach the psychiatric department early, when the most satisfactory treatment can be given. The diagnosis must frequently be made by the tedious process of exclusion, because a psychoneurosis may occur as an associated condition with any serious disease. This association renders diagnosis exceedingly difficult because the clinical picture of the serious disease will be greatly modified by the psychoneurosis. It is important that the mental state be recognized and that the process of diagnosis be not unduly prolonged. In no condition is prompt recognition and adequate treatment more important. The most resistant cases are those that have been prolonged by medical or physical treatment in the belief that the symptoms are organic rather than functional in origin. If recognized early, many of these patients require no more than a brief discussion of the nature

of their symptoms and reassurance by the examining physician.

The groups of diseases discussed above serve to illustrate the close association between physical disease and mental ill health. They are examples of patients who are not usually admitted to the psychiatric service, but who are in need of much psychiatric therapy. The first group is that in which the mental change is the result of physical disease. The second group is that in which the mental abnormality is at least an indirect cause of the physical condition. The third group includes those conditions in which the mental disease simulates physical disease. These three groups emphasize the importance of mental hygiene to the general hospital. Most of these patients will be admitted to the general services of such a hospital rather than to the psychiatric department.

The use of recreational therapy, occupational therapy, and similar endeavors are invaluable, but they must be supplemented by a study of the patient's individual problems and a definite attempt to assist the patient to adjust himself to any changes that are necessary as a result of the illness that has brought him to the hospital.

THE PLACE OF THE MENTAL-HYGIENE CLINIC IN THE COMMUNITY *

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IT is now generally recognized that there is a growing need for psychiatric service in the community, especially for that large group of persons for whom the cost of private psychiatric care is prohibitive. Prompt attention to a mild or an incipient mental disorder may well determine whether an individual will be able to take his place again as a useful and productive member of society or will go from bad to worse and eventually require care in a mental hospital.

The Lynn Mental Hygiene Clinic was established in 1929 [1] as a free clinic for adults. It is held weekly in the outpatient department of the Lynn Hospital, but it is conducted by the staff of Danvers State Hospital. During the nine years of its existence the clinic has had a steady growth, indicative of the service it offers the community and the need it meets. Patients have been referred from a wide variety of sources—numerous hospitals and clinics, physicians in the community, social-service and government agencies, mental-hygiene organizations, clergymen, and private individuals. The purpose of this paper is to point out the possibilities of a clinic such as this, conducted under the direction of a state hospital with the coöperation of a local general hospital.

Set-up of Clinic.—The clinic has access to the medical resources of the Lynn Hospital and other outside clinics, thus making it possible for each patient to receive the advantages

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[1] This clinic was founded by Dr. Clarence A. Bonner, Superintendent of Danvers State Hospital. For the first five years it was under the direction of Dr. Salomon Gagnon, now Assistant Superintendent of Metropolitan State Hospital, Waltham, Massachusetts. The present staff, in addition to the writer, includes Edith M. Mason, social worker; Grace H. Kent, Ph.D., psychologist; and Reverend Russell T. Loesch.

of adequate physical and laboratory studies. Not infrequently patients have been referred in whom careful examination has revealed the presence of some serious somatic lesion, with grave complicating mental symptoms, and in whom the alleviation of the organic condition has completely relieved the mental symptoms. In carrying out psychiatric treatment, we endeavor to take full account of any somatic ailment and its effect upon the mental state.

In addition to the psychiatrist and his assistant, the clinic staff includes a psychiatric social worker, a psychologist, and a clergyman.

A social worker trained in psychiatric technique is most essential to the success of a mental-hygiene clinic. Her report on the home environment of the patient enables the psychiatrist to obtain a well-rounded picture of the family situation. The conference between physician and social worker, before the first interview with a patient, plays an important part in the preliminary study of the case. In later home contacts, the social worker enlists the coöperation of the entire family in carrying out the psychiatrist's recommendations.

The services of a psychologist are helpful occasionally, especially in the study of an adolescent patient who presents a problem in vocational adjustment. The formal psychometric examination is not required as a routine measure, because in many cases the patient's conversation enables the psychiatrist to make a fair estimate of his mental capacity.

In as much as the services of a clergyman in a clinic are not so widely understood, it may be well to describe them at greater length.

There are cases in which the psychiatrist needs the help of a clergyman, especially in gaining the confidence of a deeply religious person about a religious problem that may be an element in the mental illness. The possibilities of religious therapy in conjunction with psychiatric treatment are receiving increasing recognition.

There are those for whom religious faith has little meaning beyond the hope of gaining personal ends in answer to prayer; and there are still others in whom the essential selfishness takes a more subtle form—who become so deeply con-

cerned for their own individual salvation and their own spiritual needs that there is little place in their lives for normal activities and social contacts.

Among our patients who have been especially responsive to the influence of the clergyman, we find such cases as the following: an emotionally unstable woman who had so abandoned herself to religious ecstacy as to neglect her home and her household duties; a conscientious girl, of rather low mentality, who was overwhelmed with feelings of guilt over an incident in which she had been the victim of an aggressive man; and an overdependent woman who had sought in religious life an artificial support that would relieve her of the responsibility of developing a normal and mature self-reliance. Under the guidance of the clergyman, these women developed a broader outlook on life. Instead of allowing their religious zeal to submerge all other interests, they were led to find in their religious experiences a deeper appreciation of social obligations. In such cases it has been found helpful to invite the patient to discuss her problems freely in joint conference with psychiatrist and clergyman, thus reducing the danger of encouraging her to become excessively dependent upon either. The physician and clergyman work hand in hand in rehabilitating the patient and restoring her to a life of greater usefulness and happiness.

Relationship of Clinic to General Hospital.—In the general hospital we observe an increasing number of patients, with presumably organic illnesses, who are actually suffering either from purely mental disorders or from conditions in which the organic disease is a minor factor. The somatic complaints may serve to distract the attention of the physician from a more deep-seated condition in which subtle psychological mechanisms perhaps play the dominant rôle. These are the patients in whom psychogenic manifestations are frequently confused with somatic illness, and who may be operated upon unnecessarily. Upon being subjected to operative trauma, such patients find their symptoms aggravated and thus are hastened toward chronic invalidism.

Among the accident cases received in the general hospital, there is a considerable number of patients who have made clumsy and unsuccessful attempts at suicide. It has been far

too common to give them emergency treatment and then—without ascertaining the underlying mechanism of the suicidal wish—to discharge them as soon as the immediate symptoms are relieved. It seems little short of criminal to send such a person back to the environment from which he was trying to escape and to make him face again the same perplexing problems that he has been unable to solve, when it is so plain that he needs something more than first-aid treatment. With his despondency reinforced by newspaper notoriety and perhaps by physical scars which constantly remind him of his shame and defeat, it should be no cause for wonder if he leaves the hospital with a firmer determination to end his life, nor if he is shortly brought back in a condition beyond medical aid.

Such cases in increasing numbers are being referred to the mental-hygiene clinic for study and treatment. In no case is psychiatric care more urgently needed than for one who has lost all desire to live; and in no case will the physician experience a deeper sense of satisfaction and achievement than in helping this patient find his courage to go on—in restoring hope and confidence where there have been only futility and despair.

Another group referred by the hospital to the clinic includes those patients whose self-inflicted injury represents only a pretended attempt at suicide rather than a genuine suicidal wish. When a young girl melodramatically slashes her wrists in order to gain attention, it is for the psychiatrist to point out to her the essential selfishness of such an appeal for the sympathy of her family and friends.

Thus the general hospital receives from the clinic a psychiatric consultation service for the benefit of the house patients and for any who may require follow-up psychiatric care after their discharge from the hospital. In this way the clinic has become an integral part of the hospital.

The Psychiatric Approach.—The operation of a mental clinic requires a more individualized technique than is necessary in conducting a clinic or dispensary for somatic diseases. Patients who seek relief from pain are willing to wait in line for attention and are usually ready to accept whatever treatment is offered. The mental patient, on the other hand, might

easily be frightened away by an abrupt and hasty approach. It becomes quite essential to cut red tape, to foster a genuine feeling of warmth and friendliness, and to keep the approach to each patient as personal and informal as possible.

Our patients are seen only by appointment. Their problems are highly individual, and all possible effort is made to adapt the psychiatric technique to the patient.

Prolonged and careful study is required for understanding the basic psychological mechanisms and their application to the patient's problems. Reëducation along constructive lines is of necessity a slow process, because the habits of thinking which bring a patient to the clinic are usually of too long standing to be easily and quickly broken up. It does not follow, however, that a patient should be permitted to become permanently dependent upon the clinic. Patients are gradually weaned away by increasing the intervals between their appointments, and they are encouraged to develop confidence in their own ability to handle their problems.

Further consideration of the technique employed will be taken up in connection with selected cases described below.

Classification of Cases.—The cases referred to our clinic represent a cross section of the entire field of mental suffering. If it were considered necessary to group them according to conventional psychiatric categories, a large proportion of them would be diagnosed as cases of psychoneurosis in its various forms. However, there is nothing to be gained by forcing these cases into fixed and clearly defined pigeonholes. It seems more worth while to offer a general description, with illustrative cases, of eight groups which include a large majority of our patients. Naturally, there is enough overlapping among these groups so that almost any patient might be placed in more than one group; but each of the cases described belongs essentially to the group that it serves to illustrate.

I. Acute mental disorders of mild types.—Many of these cases might be referred to in popular terminology as cases of "nervous breakdown." Psychogenic factors are usually well defined and overt. Most of the patients are unstable persons whose threshold of resistance is so low that a psychogenic stress, relatively slight in itself, may yet be too great for the individual to withstand. We find also home situa-

tions in which there are intolerable demands upon the patient, possibly marital difficulties or incompatibilities with their resulting infidelities. The common characteristic of this group of patients is that satisfactory results may be expected if and when the treatment can be directed at the psychogenic factor. This may require temporary removal of the patient from the difficult environment, in which event it is essential to have the coöperation of the family. Naturally there are cases in which the responsible person is uncoöperative and in which a desperate situation is so far beyond control as to make effective treatment impossible. In general, however, the prognosis may be considered favorable. This group includes also a few cases of cyclic disorder—either a periodic disturbance or repeated reactions to unpleasant situations—often followed by spontaneous recovery.

Case 1.—J.T. was a young woman, employed as waitress, who was living at home with her parents. She was described as friendly and sociable, active, fond of dancing and swimming, businesslike and a good worker, not given to worrying.

For some two years she had had severe nightmares, with increasing frequency, until at the time of consultation she was having one every night. She frequently screamed out in her sleep, so loudly as to disturb the neighbors. Occasionally she walked in her sleep. Once she rose at two in the morning and went to her place of work.

The family life seemed to be pleasant, and it was not easy to find a psychogenic factor. It was finally revealed, however, that she was in need of dental work and had developed an abnormal dread of going to the dentist. Years earlier she had lost some front teeth in an accident and had been provided with a denture which was poorly fitted. She had continued to wear this plate year after year rather than submit to the pain of further treatment, realizing that her natural teeth were becoming involved by reason of neglect, but stubbornly refusing to face the issue.

This patient was encouraged to resolve the conflict instead of evading it, and with some difficulty she was finally persuaded to seek an appointment with a dentist. She was given triple bromides in preparation for the ordeal, and her fear was so far conquered as to make it possible to have the dental work done. Her disturbing dreams gradually diminished, and when last interviewed, she reported only one nightmare in a period of six weeks.

Case 2.—F.Z., a thirty-eight-year-old widow, was responsible for the care of her four children and her aged mother. It was a source of deep humiliation to her that she had to depend upon Mothers' Aid for support, so she attended evening high-school classes in the hope of obtaining office employment. It seemed to her that there must be something wrong with her head, because she could not remember so well as formerly.

She complained of feeling worried and shaky, also reporting a lump in her throat whenever she became annoyed or upset. She blamed herself for her husband's death, on the ground that she had been unable to give him proper care in his illness. She felt very inadequate and inferior, unable to carry the responsibilities of caring for her family.

The psychogensis of her symptoms was carefully explained to her, and she was encouraged to widen her interests. She obtained an opportunity for employment—selling corsets from house to house. She accepted this work very reluctantly, and her promise that she would give it a fair trial was all that kept her from giving it up. Gradually she became interested in her work, and discovered that she possessed an unsuspected aptitude for salesmanship. Various neurotic manifestations completely cleared up, and her self-confidence was restored. At the latest report she was supporting her family, while at the same time managing the home in an orderly manner. This patient represents a very satisfactory response to clinical therapy.

Case 3.—This case is offered as an illustration of a failure to obtain lasting results without the coöperation of the patient's family.

F.S. was a woman of thirty-eight, the mother of seven children, in poor physical health, with a husband who was unsympathetic and tyrannical. Married at eighteen, she had continued for many years to work in laundries, leaving her mother in charge of the home and the babies. After her mother's death, she had had to take care of the house and children, on a reduced income and with no money of her own. She also had had to assume the care of her aged father, who kept her upset by incessant talk about spiritualistic manifestations. There was friction with the husband over his financial management, and the older children became unruly and impertinent. The patient became exhausted and sleepless, developing many obsessions and compulsive ideas. Once at night she held a hammer over her husband while he was asleep, and at another time she had an impulse to throw a crying baby into the furnace. She had a great fear of broken glass, and was in terror at the thought of having her arms cut off. At times she had ideas of suicide.

With the aid of the Red Cross, arrangements were made for employing household help so that the patient could be sent away for a visit with friends. During this vacation she showed marked improvement, but the phobias reappeared when she returned home. The Red Cross would have assisted further in employing help, but the husband forfeited this aid by refusing all coöperation.

The patient's temporary improvement indicates that the mental symptoms would have responded to clinic treatment if the family situation could have been brought under control.

Case 4.—L.McK. was a man of forty who had had infantile paralysis at the age of five and had recovered, with some residua. He was somewhat dependent upon orthopedic devices, but had never been unduly sensitive about his handicap. He was married and had two children.

Owing to the residua of the disease, the patient was obliged to change his occupation. The Division of Vocational Rehabilitation arranged for him to have training for some metal work which could be performed in

a sedentary position. But he had lost confidence in himself and feared that he would never be able to do the work. In order to "steady his nerves," he smoked more heavily and drank a great deal of tea. When referred to the clinic by the Rehabilitation Bureau, he was smoking fifty cigarettes a day and drinking over twenty cups of strong tea. He showed marked body tremors, and announced spontaneously that he had an "inferiority complex."

To the psychiatrist, however, it seemed that the patient's tremors and "nervousness" were due to the heavy intake of toxins rather than to any profound sense of inferiority. He was advised to curtail his use of tobacco and tea, and was encouraged to give his metal work a fair trial. He gave excellent coöperation, and the case was easily handled. At the time of the last report he had given up his tea entirely and was smoking only occasionally. He was enjoying his new work, and his self-confidence was well restored.

Case 5.—C.H. was a woman of thirty-six, the mother of five boys, ranging in age from seven to eighteen.

This family was found living in a three-room house not supplied with running water. The entire family slept in one room, reached by a ladder stairway from the living room. The house was clean and in remarkably good order.

The patient complained of palpitation, indigestion, and headache. It was clear from the first, however, that her marital difficulties were at the base of her symptoms. The husband had been abusive both to his wife and to the children, and had been negligent in his support of the family. His sexual demands upon his wife had always been excessive. For many years she had submitted to what she considered a wife's duty, but of late she had refused marital relations. The two older boys were helping their mother financially, and she wished to leave her husband and set up a separate home for her children. She had become embittered toward her husband, because of his abusive treatment and especially because of his neglect of the children. At times the boys were willing to help their mother in her plans for the home, but they were somewhat inconstant in their loyalty to her, having reached an age at which they felt ready to strike out for themselves.

The husband was interviewed at the clinic, and was found to be reasonably coöperative, although rather opinionated. He could not see his own faults, but he felt it very keenly that his wife had been remiss in her marital duties. It was carefully explained to him that he had been inconsiderate in his marital demands. It was pointed out to him that by his unreasonable and unyielding attitude he was breaking up his family, losing the affection of his wife, and turning his sons against him. He was finally prevailed upon to make some concessions, which the wife was advised to accept in a gracious manner. She was further counseled to be more forgiving and to meet her husband at least halfway.

Plans were made for moving the family to a larger and better house. A family conference was held at the clinic, in which all except the younger children were invited to take part. The entire family developed a more coöperative spirit, and harmony was restored. The patient's somatic difficulties subsided as soon as the domestic stress was relieved.

II. Chronic cases of mild mental illness.—Most of the cases in this second group are psychoneurotics of very long standing. These are the patients who are known to the social agencies as going from clinic to clinic and from physician to physician, always demanding help, but rarely showing any willingness to help themselves. The outstanding symptom is the fixation of the patient's attention upon his symptoms, whether in the somatic or the psychic field. The mechanism may be an obvious effort to escape from responsibility, or in some cases an attention-seeking device to compensate for a difficult situation. These patients are extremely self-centered, craving sympathy and talking incessantly about their ailments. Very often the condition can be traced back to childhood. With the passing of years, it becomes more intense, and with the appearance of organic illness in later life, there is frequently a marked exacerbation of symptoms. Unable to adjust to their infirmities, these patients become querulous, nagging, and very difficult to live with. An invalid of this type may very well break up the morale of an entire family, and often enough we see reflected symptoms in children, who may by imitation develop an attitude similar to that of the parent.

Even in this unpromising group, a gratifying response may be elicited by an appeal for improved habits and attitudes, variations in routine, and changes in environment. These patients do not take criticism well, and it is necessary that the physician fully establish himself in their confidence before making any critical attack upon their attitudes and symptoms.

Case 6.—J.C., referred by the public-welfare department, was a man of forty-eight, single, dependent upon aid from the city. He was living alone in a lodging house. He complained of numerous somatic ailments, especially a pulsating sensation in his chest with a noise that at times sounded like words. He was actually suffering from severe arthritis as well as from an organic heart condition, but the symptoms were grossly exaggerated in his mind, and his attention was completely centered upon his physical condition.

J.C. had formerly been employed by the Christian Science Publishing Company, and had worked also as a salesman of electrical appliances. He was an intelligent man, and until he had become ill some two years before being referred to the clinic, he had been able to take care of himself comfortably. Many years earlier his fiancée had been killed in an accident. After her death he did not form any other serious attachment, but until his illness he continued to keep up some social interests.

Symptomatic treatment for his somatic ailments was made the point of departure for psychotherapy. It was explained to him frankly that a complete cure was not to be expected, but he was encouraged to hope for some alleviation of the symptoms through medication. He developed confidence in the clinic and responded well to suggestion. He was encouraged to make more use of the library and to take up such activities as his health permitted. He was referred to various clinics for further physical studies, and obtained some relief. His hypochondriac symptoms were diminished, although they did not entirely disappear. His condition was fluctuating, showing on the whole decided improvement.

III. Inherent personality disorder.—This group includes some frank cases of psychopathic personality, and some milder cases which might formerly have been diagnosed as "moral imbecility." Defective or inadequate training in childhood figures largely as an apparent causal factor, and it is not unusual to find emotional instability or moral weakness running through the entire family. Too often, however, we find the sporadic case—the so-called "black sheep," who is a source of infinite sorrow and anxiety to an excellent family.

The most characteristic symptom is an overweening selfishness, which leaves no place for a decent consideration for others. Emotional development and moral responsibility are on a very low level. The man of this type may have so exaggerated a sense of self-importance that the good opinion of others is in no way necessary to his self-esteem. His marriage is naturally unsuccessful, because he marries merely for self-indulgence and with little thought of assuming any responsibility for his family.

Defect in personality varies widely in degree. In some cases we find vicious psychopathic tendencies, with sexual perversions and other antisocial behavior. There is little that can be done for the extreme psychopath, because he lacks the worthy aims and incentives toward which a moral appeal might be directed. He may even scoff at any appeal to higher ideals and motives. There is hope, however, for any one who is capable of caring deeply for some one other than himself. Friendship, love, and parenthood have been known to effect a marked change in the character of an intensely selfish man or woman.

Case 7.—J.B. was one of the patients with whom the clinic was unable to achieve any measure of success.

He was a man of twenty-seven, married, with three children. Since his marriage, which had been a forced one, he had been soliciting aid from one agency after another, without making any serious attempt to support his family by his own effort. He was offered a W. P. A. job, but did not report for duty because it was not good enough for him. He has passed worthless checks and has forged his brother's name to checks, depending upon his family to protect him. Once he served a short sentence, and he stated that this punishment made him all the more anxious to steal. No reliance could be placed upon his word. He was always informing his wife that he had some scheme for making money, but the only real capacity he manifested was for spending. Every day he brought home ice cream and candy for the children, and occasionally he bought high-priced toys for them on credit.

Superficially he took a keen interest in religion. He sent the children to Sunday School regularly, and was careful to have them commit the texts to memory.

This patient attended the clinic under pressure, having been referred by a social agency. He was resentful at first, but became more responsive in the course of the interview. Shortly afterward he was arrested on a serious charge, and was given a long sentence. The case was closed for this reason.

IV. Subnormal mentality.—In addition to cases of frank mental deficiency, this group includes persons of dull, borderline, and low-average mental capacity; also some of inferior personality whose intellectual capacity, as measured by tests, is within normal limits.

These are the persons who, beset with inferiorities, find themselves in a muddle of difficulties, helpless in the face of adversity. Here frequently is seen a tendency to lean too heavily upon the clinic, looking upon it almost with reverence. This dependence should, of course, not be encouraged. Rather should the clinic foster an attitude in which the patient is able to see his problems more clearly and ultimately to handle his difficulties without assistance. The course of treatment to be followed depends upon the patient's mental level and his capacity for being trained, also upon the intelligence and coöperation of the family.

Case 8.—E.D., a woman thirty-six years old, had suffered some arrested development after an illness at the age of five. She was living alone in a tenement room, keeping house for herself with the aid of a small maintenance allowance received from the city. At no time self-supporting, she had been cared for by her mother until two years before the time of consultation. Since the death of her mother she had felt utterly alone and helpless.

She complained of various somatic disorders—dizziness, pain in stomach, backache. She stated that she tired very easily, had blue spells, and that she cried every day. She had applied for treatment at many clinics, each of which merely referred her to some other clinic.

A satisfactory contact was easily established, and her responsiveness to the friendly interest of the clinic was almost pathetic. It should not be expected that this woman can become wholly independent of counsel and guidance, because she is hardly more than a child in mentality and judgment; but enough aid to keep her from becoming an institutional case can be given with very little effort. Her despondency and sense of utter hopelessness have been overcome, and a clinic appointment to which she can look forward is now sufficient to keep her cheerful for several weeks. Her recreational interests have been developed, and she has a little more to live for. She continues to have somatic ailments, but bears them with better courage.

Case 9.—M.S. is a woman of forty who has made a poor adjustment to life. Her marriage was unhappy, and after a few months husband and wife separated by mutual consent.

One child was born of this union, and because of the mother's inability to give it proper care, it was taken over by the State Division of Child Guardianship. This child, at eleven years of age, had turned against her mother, who had given her very little attention while she was being brought up in a foster home. When the patient began to realize that she had lost the affection of her daughter, she developed symptoms of depression, accompanied by some physical manifestations. Being a person of rather low mentality, she felt helpless and in need of counsel as to how to meet this problem.

Some improvement was obtained by a process of education in the matter of maternal responsibilities. It was explained to her that children give their affection to those who take care of them, not necessarily to those who are related to them by blood; and that the love of one's own child is something to be earned rather than something to be taken for granted. It was made clear to her that she should not expect any immediate change in the child's attitude; but she was encouraged to hope that, by patient effort and constantly maintained consideration, she might yet be able to win the affection of her child. Because of her heightened tension, she was given a mild sedative.

M.S. responded well to this reassurance, and her somatic symptoms soon subsided. She now feels more hopeful about her child and the future.

V. Adolescent behavior problems.—Our clinic is not intended to encroach upon the important work carried on by the child-guidance clinic, but is intended to serve an age-group not covered by that clinic. There are young people who are in need of help in making the transition between adolescence and maturity, in preparation for the duties of adult life. Some need advice on such matters as further education and training; and others—those who have completed

their formal schooling and who look upon the economic world with a certain bewilderment and confusion—are in need of vocational guidance and counsel. In their haste to emancipate themselves from the authority of the home and to secure independence, both economic and social, these youngsters often come into violent conflict with parental social standards. Frequently it is a conflict between Old-World and New-World ideals, the fixed and rigid attitude of the parents giving rise to a serious problem in guidance. Successful handling of the situation may involve careful reëducation of the parents, along with some curbing and reorganization of certain adolescent drives. The services of teachers, clergymen, and social workers are of great value and are freely utilized. These problems are demanding increasing attention because of our rapidly changing times, and because of the grave social and economic conditions that they involve.

Case 10.—M.McC., a girl of seventeen, was a senior in high school, especially interested in commercial courses, but doing barely passable work in other subjects. She was slightly overweight and was exceedingly sensitive about it.

There was a younger sister who had a better physique and who was a better student. The patient was fond of her sister and very proud of her, but she considered herself inferior in comparison. At an earlier age she had rebelled against going to dancing school because she had thought herself too fat to be a desirable partner. As she grew older, she stayed at home very closely, and could rarely be persuaded to go out in the evening. She was helpful at home, and her services were appreciated by the family, but she refused to take her place as a full member of the family group. She was a poor sleeper, was inclined to worry about her school work, and became very irritable on slight provocation.

Treatment consisted largely of reassurance. The psychometric examination revealed average mental capacity, with evidence of good ability both in speed and in accuracy. On the strength of this she was encouraged to take secretarial training. She was advised to improve her physique by exercise, and she responded well to this suggestion. She became interested in tennis, played with boys, lost some weight, and became more graceful. Her shyness broke down and her self-confidence was built up. At the latest report she was able to meet people naturally, and was much more cheerful.

Case 11.—W.F., a nineteen-year-old student, was referred to the clinic in a mild state of depression. He was the youngest of four siblings, the other three of whom were quite successful in business or professional work.

W.F. had been a stamp collector for many years, and his interests were almost entirely limited to his collection. He was taking a commercial course in a local university, but was neglecting his work. He had withdrawn himself from his friends, and was spending hours with his collection, to the exclusion of other interests normal to a young man. His only social contacts were with elderly persons who were also interested in stamps. It appeared that his tendencies were in the direction of schizophrenia.

W.F. would have welcomed the advice that he discontinue his studies and make stamp collecting his vocation, and the problem was obviously one of vocational guidance. It was carefully explained to him that any reasonable chance of success as a stamp dealer would call for resources which he did not possess, and that he might better keep his collection as a hobby. It was explained further that by his excessive attention to his collection and his gradual exclusion of other interests, he was developing an unwholesome attitude toward life; and he was advised to diversify his interests in order to maintain sound mental health.

At this time an opportunity arose for him to obtain part-time employment as usher in an outdoor theater. He was encouraged to take this work, and was advised to reduce the time spent with his collection. Gradually he regained confidence in himself, and resumed some of his social activities. He is now planning a business career.

Case 12.—D.G. was a fourteen-year-old girl, rather large and well developed for her age, who was causing her parents serious anxiety by staying out late at night in the company of boys. She had recently become rebellious against parental authority, and had developed nervous mannerisms, such as finger sucking and temper tantrums.

Interviews with her parents threw some light upon the behavior of this girl. The mother talked incessantly, and it was clear that the girl was subjected to intolerable nagging. The father was irritable, but indulgent, and there was constant friction between the parents in their efforts to control their daughter. It appeared that the girl's defiant attitude was an attempt to break away from the domination of her parents. Considerable educational work was carried on with the parents, to help them realize that their daughter was becoming too old and too mature to be held in check like a small child. They were advised to treat her with greater latitude and to respect her wishes in unimportant matters.

It was pointed out to the patient that she was not handling her problems in a mature manner. She was led to see that her demonstrations were undignified in a girl who wished to be respected as an adult, and was made to realize also that she still owed her parents more obedience and consideration than she was giving them. She responded well, developing a changed attitude toward her parents and making considerable effort to overcome her mannerisms.

This girl expressed interest in dietetics and nursing, and in order to encourage this interest the mother was advised to allow her to assist with the cooking at home. The patient responded satisfactorily, becoming more helpful at home and taking pride in her work. The parents were very much pleased with the change in their child.

VI. Organic neurological conditions.—The patients of this group present a wide variety of mental manifestations, the predominating symptoms being intellectual deterioration and emotional instability. The group includes hereditary and degenerative disorders, multiple sclerosis, post-encephalitis, poliomyelitis, post-infectious and toxic disorders, vascular disorders, and other similar conditions. Despite the severity of the organic changes, a great deal can be done for these patients by a process of reëducation. The patient may be taught to adjust better to his infirmities, to acquire a greater degree of emotional control, and to develop a warmer and more tolerant philosophy of life.

Case 13.—J.McG., a fifty-year-old married man, had been seriously ill with encephalitis in 1918. A few years before coming to the clinic he had noticed stiffness and weakness of the upper extremities, with tremors. Having suffered an injury to his left arm in 1935 at his place of work, he believed that this injury was responsible for his present symptoms, but was unable to obtain any compensation. His condition was becoming gradually worse, and he had become quite despondent.

A careful examination revealed the presence of paralysis agitans, and it was ascertained that the injury had played no part in the symptomatology. This was explained to him, and he was then encouraged to hope that the symptoms might be alleviated by medication, but it was made clear to him that he should not expect a complete cure. He was accordingly put on stramonium, and showed a very gratifying response to this treatment. He dropped his claim for compensation, adopted a different attitude toward life, seemed much more hopeful, and accepted his infirmity with considerable composure.

VII. Frank psychoses.—There is a limited group of frankly psychotic patients who may be adequately cared for in the home. Some of them do considerably better in the care of the family and under the supervision of the clinic than in the strange atmosphere of an institution with locks and bars. Of course it involves a heavy sacrifice on the part of the family, and it is questionable whether it should be undertaken in a home where there are young children.

The clinic is not intended as an after-care agency for patients who have been discharged from a mental hospital. However, there is occasionally a patient who on his release from the hospital is accepted as a clinic case, on the ground that further psychiatric care may restore to productive life

in the community a person who would otherwise be unlikely to attain that goal.

Case 14.—L.S., a man of fifty, had worked twenty-five years for the same company, but when the depression came on, he with other employees was discharged in order to cut down overhead. He was reduced from a very active life to a relatively colorless existence. He felt that he had been mistreated by the company, after so many years of loyal and faithful service. Gradually he developed ideas of reference, began to distort his environment, and even misidentified members of his own family. It was believed that he was suffering from involutional psychosis of the paranoid type.

His wife was very reluctant to place him in an institution, and the entire family gave excellent coöperation in carrying out the recommendations of the clinic. Various activities were planned for him, especially the making of a garden of which he became very proud. He enjoyed his visits to the clinic and took pleasure in describing his new occupations and interests. Gradually he developed insight into his delusions, and apparently made a complete recovery from his breakdown. It was a source of great satisfaction to his family that they had been able to care for him at home.

VIII. Miscellaneous maladjustments.—Our eighth and last group includes a variety of cases of maladjustment, especially domestic discord and marital incompatibility. The symptom common to them all is dissatisfaction—not the constructive discontent that leads to an effort to better existing conditions, but rather a shallow and self-centered pessimism that makes for unhappiness even amid attractive surroundings. These individuals seem to feel that they have not been treated quite fairly, that life owes them more of happiness than they have received. Weak in emotional control, some of them are unduly upset by each petty annoyance of the day. The group includes also some who are so sensitive to a thoughtless or playful criticism that they go about almost habitually nursing hurt feelings.

It is the task of the clinic to teach these persons how to make their own happiness instead of passively waiting for it to come to them. Considerable stress is laid upon habits of living that are favorable to health. It is important that they acquire a sturdier emotional control, that they develop more insight into their own responsibility for their dissatisfaction, and that they learn to make concessions to others. Any constructive effort that they can be induced to make is of

value, even the development of a hobby. The clinic can accomplish much for them by teaching them to find more enjoyment in the things that they have and in the friends whom they may win.

Case 15.—A.P. was a thirty-three-year-old married woman, with two children. She had become pregnant by her husband at an early age, having yielded to his wish without fully understanding what she was doing. They were married shortly afterward, but the marriage had been unsuccessful from the first. The husband was a man of coarse tastes and untidy habits.

They lived in a two-family house, the other apartment of which was occupied by a single man who owned the house. A friendship, which developed into a sexual relationship, grew up between the patient and the landlord, and it was from him that she first experienced satisfaction in the sexual act.

Later the landlord married, but still continued to meet the patient occasionally. She became very jealous of his wife, and fell into the habit of eavesdropping. She did not love the landlord, but had become very dependent upon him for sexual satisfaction. She was greatly troubled, both by feelings of guilt and by the fear that the clandestine affair would be exposed. She developed various somatic symptoms which she herself believed to be imaginary, and it seemed to her that suicide was the only way out of the difficulty.

A.P.'s husband was invited to come to the clinic. He was a large, clumsy man, rather immature and boyish in his make-up. He was given careful instructions in the technique of the sexual act, and also some suggestions about his personal habits in the home. He stated repeatedly that he loved his wife and that he wished to coöperate fully with the clinic.

At her next visit A.P. was able to report some improvement in her relationship with her husband. She responded well to the change in him, and earnestly endeavored to reconstruct their married life on the basis of better understanding.

In order to make it easier to break up the illicit relationship, a change of home was clearly indicated. A.P. wished to have an independent reason for giving up their apartment, so that her husband's suspicions might not be aroused. Accordingly she sought employment at a summer resort, and arranged to have the children boarded in a neighboring home. When last heard from, she was enjoying improved health, was successfully carrying out the recommendations of the clinic, and was expecting to take another house in the fall.

Case 16.—J.W., a forty-one-year-old married woman, was referred by The National Committee for Mental Hygience, to which agency she had written for counsel. Although a woman of rather superior intelligence, she was developing feelings of inadequacy with regard to her daily problems.

J.W. was approaching the menopause, and was in need of some perineal repair work. In addition to her anxiety about this, she felt unduly concerned when one of her children became sick, although she knew that the

child's illness was not serious. There had been some friction with her husband, who was an aggressive individual. The situation seemed hopeless and she felt unable to carry on. Her dissatisfaction with life led her to look upon the future with some dismay.

Progress with this patient was made very slowly. She came frequently to the clinic for reassurance, and her feeling of inferiority was minimized. Gradually she developed confidence, after which it was a simple task to restore her to her former level of adequacy and self-assertiveness.

After her recovery from a plastic operation, she was encouraged to resume some of her former social activities, which she had dropped. She responded with considerable enthusiasm, and soon became secretary of a women's club. Having come to a better understanding with her husband, she developed a different attitude toward the domestic problems and felt confident of her ability to meet them as they should arise.

Case 17.—W.D., an electrician, forty years of age, was an exceedingly conscientious individual who worked regularly and who accepted his responsibilities seriously.

About ten years before coming to the clinic he had married a woman who was quite unstable and who had had a mental breakdown. He was devoted to his three children, and also to his wife, despite her frequent outbursts. He was of the "milk-toast" type, and his whole attitude was one of submission.

After a quarrel over a trifling matter, his wife ejected him from the house and refused to let him see the children. Miserable and heartbroken, he came to the clinic in despair, desirous of returning to his home on any terms.

His wife was visited by the social worker, who found her quite adamant in her attitude. W.D. was advised to remain away from her for the present, and after a reconciliation had been effected, to adopt a different attitude and be more assertive. When he returned home several weeks later, his wife had come to realize that she had been at fault. She has since been considerably more agreeable to him and more reasonable in her demands upon him. Amicable relations have been reëstablished, and the domestic situation is greatly improved.

Case 18.—G.F., a woman fifty years old, had been married rather late in life to her present husband. The marriage had been successful until the outbreak of illness in the husband's family, after which he became responsible for the support of two sisters and a brother. This caused considerable tension in the home, and the husband, quite distraught by his overburdening familial cares, became irritable and upset. The patient reflected the attitude of her husband and reacted to the situation by tearful outbursts. Her point of view was extremely self-centered; she felt dissatisfied because she had lost something of her husband's devotion. She sought aid from the clinic primarily in the hope of having her husband influenced to be more attentive to her.

An attempt was first made to alter the patient's own attitude—to make her more tolerant toward her husband and more sympathetic for him in his difficulties. Later the husband was led to see that his wife was entitled to a little sympathy and attention, after having had her income so unexpectedly reduced.

Thus treatment was directed toward both, and each was helped to view the situation from the standpoint of the other. The difficulties were gradually straightened out, and patient made satisfactory improvement.

The problems presented by these selected cases are fairly representative of those brought to our clinic. It is quite evident that there are in the community at large many personal problems, essentially psychiatric in nature, which involve more than one person and which cannot be neglected without giving rise to social consequences of serious proportions; that many of the persons who face these problems can effect a satisfactory solution with the aid of a little friendly counsel offered at the right time; that psychotherapy in a broad sense, including educational therapy and religious therapy, has an important place in the mental health of the community; and that it is to the advantage of the community to support a clinic that offers free psychiatric service to those who cannot possibly afford private consultation.

In conclusion, it should be stated that the cost of operating this particular clinic is relatively low, although the addition of outside work to the already full schedule of a crowded state hospital naturally calls for careful planning. The satisfaction derived from this service is ample reward for the additional effort expended. It may safely be inferred that many other state hospitals might thus extend their services to the community without waiting for special appropriations, and that such extension of service might pave the way for the support of mental-hygiene clinics on a more adequate scale.

MENTAL HYGIENE FOR THE BLIND*

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IN presenting the case of mental hygiene for the blind, it is not necessary to file a brief proving the need for this form of therapy. If a program for the emotional adjustment of children with a full complement of senses is considered important, certainly such a program is even more essential for those in whom one of the five senses is missing. "As an organic creature," it is said, "man lives by means of his senses. His daily life is one long and complicated chain of responses to their stimulation, while his education and development are mainly the incorporation of these messages into the stuff of character and personality."

To what extent does the loss or the serious impairment of one sense affect character and personality? Opinions differ on this point. Many people contend that the blind are simply "folks in the dark," just like the rest of mankind except that they cannot see. Sir Ian Fraser, war-blinded Englishman, writes:

> "On the whole, I should say that blindness in itself does not induce an abnormal outlook on life. A blind man sees what he wants to see. His outlook is happy, if he is happy."

J. R. Atkinson, of California, has a different point of view. He writes:

> "I have always looked upon my own blindness not as an affliction, but as a handicap to be overcome. When a person realizes that he or she has a handicap, it is possible to set about overcoming it."

Ralph V. Merry, in his book, *Problems in the Education of Visually Handicapped Children,* admits personality difficulties, but does not charge them all against the loss of sight.

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> "While blindness may be responsible directly for certain personality difficulties," he states, "it seems more reasonable to suppose that the majority of these maladjustments result from the social situations arising from lack of vision, rather than from the physical handicap itself. . . . Thus, maladjustments frequently attributed to blindness in reality may be the result of institutional environment, or an unsatisfactory adjustment with other children."

Thomas D. Cutsforth, author of *The Blind in School and Society,* takes a more definite stand:

> "It is generally supposed that blindness represents the mere absence or the impairment of a single sense. On the contrary, blindness changes and utterly reorganizes the entire mental life of the individual. The earlier this frustration occurs, the greater the reorganization that is demanded and the greater, also, the effect of the frustration upon seeing individuals whose attitudes determine the hygiene of the blind."

All of these statements are from blind persons, since after all, they are the only ones who can speak from experience in this realm, and their testimony alone on this point should be considered. From the point of view of the sighted, the blind live in but a segment of the full orbit of the sun on its daily course. Those who see enjoy the full light of the midday sun, the fading hours of twilight, and the darkness of the night, but this without fail is dispersed by dawn and another day. The blind never know this full course. Their whole life falls within the small segment of hazy dusk (in the case of those with partial vision) or the full darkness of night, which has no end.

Despite the conflicting evidence of the blind, living in perpetual darkness *must levy* its toll on the emotional life. Although, as a blind man once said, the warmth of the sun can still be felt, not to see its brightness, not to glimpse the radiant beauty of sunset, and not to know the loveliness of the first rays of dawn, is to be deprived of one of the most enriching influences of life. These visual impressions, so vivid to the seeing, cannot be conveyed fully to the mind when sight has gone, even by the most realistic description. To what extent, then, does this deprivation color the emotional outlook? W. J. Voss, speaking for the totally blind, writes:

> "The fact that one sense has never functioned at all must necessarily warp and throw the whole of life out of its true perspective. It is like

that of an animal, or plant, whose growth has been distorted by the want of some needful element for its nourishment."

Not all with whom we as educators deal are totally blind—that is, do not see at all and never have seen. The number of congenitally, completely blind persons is very small. Starting from that absolute condition, the defective vision of most of our people represents a number of different causes and varies in degree up to the maximum of sight accepted for admission to our school, which is 20/200 on the Snellen chart. This further complicates the emotional problem, because the outlook on life of a person with some sight must differ from that of one who is totally blind. One would think that the presence of some sight should ease the situation. As a matter of fact, it often adds additional burdens—the constant fear that remaining vision may depart and the confusion that arises from not seeing things clearly. Only the other day parents of one of our pupils who came to see me were surprised to find a certain member of the staff so young and pleasant. Their child, in letters home, had pictured her as old and far from gracious. I cite this merely to show the possibility of forming wrong judgments because of blindness.

Our pupils divide themselves rather automatically into two groups. Those who are totally without sight are known as "goats," and if, upon hearing that appellation for the first time, one should ask why, the reply would be: "Don't goats go around bumping into people? So do we." While this is perhaps another way of lightly passing off their handicap, it is an interesting classification, and has some bearing upon the psychological attitude of these totally blind. Recently I learned that sheep can see only about fifteen yards. That is why sheep need shepherding and must be guided wherever they go. When I heard that, it occurred to me that I might venture to suggest to our partially seeing pupils that they place themselves under the classification of sheep in contradistinction to goats. The suggestion might, of course, be resented because of the implication of the need of shepherding and other characteristics which we attribute to sheep. Nevertheless, it would make an interesting grouping—the

sheep and the goats—without the biblical problem of trying to separate them. These two groups, however, with their limitations, as well as their compensations, have to be considered in formulating any program of mental hygiene, because their outlooks on life differ and not always in proportion to amount of vision.

Another factor that leads to early confusion and often to later conflict is the fact that the blind form concepts of material objects which are the reverse of those formed by the seeing. A sighted person first sees an object as a whole, and then with his eyes explores the parts, building up thereby a mental picture. A blind person gets his first impressions of an object through the parts, which he must necessarily feel with his fingers, and then builds up a concept of the whole. The process being "in reverse," it would be only natural if the results differed. Perhaps you recall that delightful poem by John Godfrey Saxe, which begins:

> "It was six men of Industan
> To learning much inclined,
> Who went to see the elephant
> (Though all of them were blind),
> That each by observation
> Might satisfy his mind."

It goes on to tell how one thought the elephant to be very like a wall because he happened to fall against its sturdy side; another, like a spear because of its tusks; another, like a snake after feeling its trunk; another, like a tree because of its legs; another, like a fan from the shape of the ear; and the last, like a rope, because the tail fell within his scope. And so they disputed because

> "Though each was partly in the right,
> They all were in the wrong!"

The moral of the poem had probably not so much to do with the partial conception of the whole that each blind man formed as it had with warning the seeing that in forming opinions they should know the whole story. I think, nevertheless, that this moral might well be applied to the blind literally as well as figuratively. From their method of sensing objects, there is likely to develop the habit of con-

ceiving things in parts and of having difficulty in bringing them together into wholeness, which may well carry over into the emotional life and cause maladjustments. Consider also the fact that the horizon of the blind is the reach of the fingers, and we have a potent factor for the development of frustration and introversion.

Another aspect of blindness, which perhaps more than anything else calls for intelligent mental hygiene, appears when we are confronted with young people, and sometimes with older people, who lose their sight unexpectedly. As many of you probably know, blindness has come to be largely an old-age problem. Two-thirds of those without sight in this country are over fifty years of age and only one-twelfth are under twenty years of age. Two-thirds of the blind lose their sight after the age of twenty, the median age being thirty-six. With older people the loss of sight does not always create serious mental difficulties. With younger people, especially those in the later school years, there is always the necessity of careful adjustment. Unless we can lead those who lose their sight to complete acceptance of the situation, there is likely to be an emotional maladjustment which changes the whole of life. This is one of the most difficult problems among educators of the blind, and it is in this aspect that we need the guidance and help of experts in the field of mental hygiene.

A number of cases of this type come to us at Perkins. Most of them are young enough to be fitted into the school life, where the routine association with blinded boys and girls finally leads to acceptance and adjustment. From time to time we have persons beyond school age whom we admit to the school for a period of adjustment. Such a case came to us a couple of years ago—a nurse who had lost her sight through an automobile accident. It was one of the most difficult problems with which we have been confronted, and we worked with this young woman for two or three months, but were never able to bring about complete acceptance since other complications, due to the accident, proved incurable. After this was determined, she left us to be hospitalized.

Another case was that of a girl who had left school before

completing the high-school course. She also had lost her sight in an automobile accident, and she simply would not accept blindness as her permanent fate. She lived in another state, but would not go to the state school because she was afraid that her friends would think her queer if she had to go to a school for the blind. She kept her eyes completely bandaged so that no one could see them, even though there was no necessity for this. After some persuasion, she was prevailed upon to come to Perkins. Our first step was to make her remove the bandages, although we compromised by allowing her to wear dark glasses. Next we showed her that she could work within the school and carry on a definite program, which would occupy her mind. Our third step was to make her associate with pupils in the school and, gradually, to go down town, where she would be seen by other people. Finally, we got her to go out independently so that she became completely adjusted to her station in life as a blind person. She has now returned to her own state school, where she is doing excellent work and showing a fine attitude. We feel that that was a successful case of emotional adjustment.

We are working on a somewhat similar problem with a boy who lost his sight through severance of the optic nerve by a bullet wound. This case has a great many complications. We brought the boy to Perkins to see what we could do for him, but our facilities were not adequate for such a serious case, so we secured the coöperation of the Psychiatric Department of the Massachusetts General Hospital. After a short stay with them, he was able to fit into the school life, and he is carrying on his work here, although he is under the supervision of our personnel department, which is watching him with great care, helping him to meet moments of depression and taking such steps as are necessary from time to time to keep him in condition to carry on his work. Whether or not we can carry through this case to complete social adjustment remains to be seen, but it is illustrative of the type of case with which we have to deal. It shows the necessity for competent understanding of what can be done in the field of mental hygiene, and the need of facilities for dealing with such problems.

There are a good many phases of life within a school for the blind that require intelligent handling from the point of view of mental hygiene. Our program of observation and guidance must begin early in school life to avoid the formation of wrong habits and the building up of fears. We have to be sure that our pupils acquire what other children learn through casual visual observation. They must be carried through the period when they learn that they are different from other children. We have, of course, all the difficulties that go with adolescence plus the complications that arise through loss of sight. One girl, recently in difficulty, wrote to ask forgiveness "for this slip up the mountain of adolescence."

As our pupils approach maturity, they are confronted with the question whether or not they should marry, and later they become deeply concerned over the possibility of earning a living and their chances in the workaday world. Unless all these problems are brought into the open, they are likely to lead to unhealthy introspection and to a sense of frustration. Conflicts arise within the minds of these young people and the conviction that life holds nothing for them thwarts the effort to prepare them for the future.

Most of the foregoing statements are based upon our own observation of a school population that averages two hundred and seventy-five blind boys and girls. Perhaps, to make the paper more comprehensive, I should bring to your attention some of the more definite problems that blind people and students of our field have set forth to prove that blindness is an adverse personality factor. One of our very capable teachers, who is without sight, presents the situation forcibly by citing four ways in which blindness affects personality: (1) it inhibits normal physical activity and limits the sources of stimulation; (2) it thwarts wish-fulfillment; (3) it increases nervous and physical strain; and (4) it makes the individual an exceptional member of his group.

A member of the staff of the California School for the Blind lists as primary characteristics of blind children: (1) lack of initiative due to emotional blocking rather than to physical causes; (2) feelings of inferiority often compensated for by bravado; (3) worry about the present and the future;

and (4) a varied phantasy life of a wish-fulfilling or a sadistic nature.

The two men who have written most authoritatively about the emotional problems of the blind are Thomas D. Cutsforth, whose study is a doctor's thesis at the University of Kansas, and Ralph V. Merry, whose *Problems in the Education of Visually Handicapped Children* led to his degree of Doctor of Education at the Graduate School of Education, Harvard University. Both of these men are blind.

Dr. Cutsforth claims that, apart from the emotional difficulties that are common to all youth, blind or seeing, the two most acute problems in dealing with the blind are (1) verbalism, the problem of words versus reality, and (2) the phantasy life of the blind.

In setting forth verbalism as a problem of the blind, Dr. Cutsforth does not blame those without sight as much as he does educators of the blind. He claims that the tendency of the blind to use words that they do not understand and words that describe experiences which are not real to them is due to the fact that schools try to convey to the blind the experiences common to a normal, seeing child, instead of restricting instruction to that which can be realized by the person without sight. "The danger of this," he states, "is that the factual content in each case is derived from the experience of others." From this instruction, "the blind, have no avenue of escape. They are compelled to continue in a world of unreality. The danger of this is that it causes blind children to discredit the world in which they, themselves, live and the experiences which they can have, and causes them to emulate the experiences of others. . . . Right then," Dr. Cutsforth adds, "the educational system has created a life-long verbalizer with the personality of a verbalizer, who dares not trust the validity of his own experience. Living, therefore, in a world which he cannot experience destroys the possibility of inner harmony and leads to conflicts."

In stressing the phantasy life of the blind, Dr. Cutsforth is keeping well within the field of emotional involvement. A great deal of importance is now placed upon the phantasy life of a child, and means must be taken to guard against the

use of this avenue of escape from reality. The door leading to this avenue is even more alluring to those without sight.

> "The phantasy life of the blind," claims Cutsforth, "does not arise from a primary physical disability, but it does arise from the social relations that such a disability involves. . . . The most unfortunate aspect of phantasy building lies in the fact that it is not the signal of social maladjustment in a small part of each personality. On the contrary, it signifies a defective organization of the whole self. Escape into unreality derives its nature from the total situation and for any individual the greater part of the environment is the self. The blind are chronic phantasy builders."

Dr. Merry is a little more concrete and not quite as vigorous in his attack as Dr. Cutsforth. From his presentation of personality problems, I select two as illustrative of his attitude. Both are practical and real. The first concerns the presence of certain tics and habit spasms, which have become so closely associated with lack of vision that they are known generally as "blindisms." The more common of these mannerisms are: (1) rocking the body backward and forward; (2) putting fingers or fists into the eyes; (3) twirling rapidly around and around; (4) shaking fingers before the face; and (5) holding the head bent forward.

After pointing out that not all blind children exhibit these habits, Dr. Merry writes, "Since their presence strengthens the popular belief that those without sight are abnormal, everything possible should be done to prevent their development." Merry feels that there is a causation for blindisms that should be studied since the only way to prevent them is to attack the problem at the source. Many feel that these acts are substitutes for natural physical activity and are accompanied by certain experiences of pleasure, which make children want to do them. Frequently, however, they are manifestations of mental difficulties that have to be resolved through mental hygiene and represent danger signals that must not be ignored.

The second problem presented by Dr. Merry is that of speech disorders, which seem to be more prominent among blind children than among those with vision. In surveys of two large institutions for the blind, Dr. Sara Stinchfield Hawk found that 48 per cent of the pupils exhibited major speech defects.

> "It seems probable," writes Dr. Merry, "that, as in the case of other personality difficulties, speech disorders are caused more frequently from conditions arising from lack of vision than from blindness itself. Thus the tendency among many parents to regard their blind children as babies much longer than is the case with their seeing children may be directly responsible for the presence of speech defects, such as lisping and baby talk. . . . Stuttering and stammering often are caused by emotional disturbances and mental conflicts, which have to be eliminated before these defects can be remedied. It is possible that the conditions resulting from blindness are more productive of these emotional disturbances than are the conditions surrounding the majority of seeing children."

Before closing, it might be well to speak rather definitely about some of the tools that we use in dealing with the mental problems of the blind. As perhaps you know, adaptations of the Binet tests for use with the blind have been made by Professor Samuel P. Hayes, of Mount Holyoke College, who is consultant in psychology at Perkins. Careful adjustment and adaptation have made them valuable indexes of mental ability. At the present time we are working on the adaptation of the new 1937 Terman scales, so that teachers of the blind will have the benefit of this more modern method of mental testing. In addition, many schools use achievement tests of various types and some of them have been put into braille.

A number of personality surveys made in schools for the blind have produced revealing results and have been helpful in formulating the problems involved. Especially to be noted are the study made by Dr. Anita Mühl, in California, and an extensive study of the blind adolescent made by Miss Gretta Griffis, of Chicago.

Perhaps the most interesting, as well as the most recent, method of measurement has been the application to groups of blind and deaf children of the social-maturity scale developed by Dr. Edgar A. Doll, of Vineland, New Jersey. This scale was designed as an objective method of evaluating the level of social behavior. After trying the scale on groups of normal and subnormal children, Mrs. Bradway applied it to handicapped children. Her object was "to find out to what extent total deafness, total blindness, and severe physical crippling are social handicaps and which of these is the greatest handicap."

For the sake of comparison, let us give her findings for the deaf and the blind:

> "The results for the two groups on the social-maturity scale showed that the blind were inferior to the deaf in social competence and that both were inferior to persons not so handicapped. The mean social quotient (S. Q.) for the deaf subjects was approximately 80±10. The mean S. Q. for the blind was approximately 62±10. In other words, the deaf showed an average handicap of about 20 per cent, and the blind of about 38 per cent, as compared with average seeing and hearing children. The average S. Q. for the deaf remained approximately 80 for each life-age group, showing a constant retardation from age to age. The S. Q.'s of the blind, on the other hand, showed some tendency to decrease with age, which suggested that blindness results in cumulative social retardation. . . . Furthermore, we found that, in general, neither deafness nor blindness constituted a permanent bar to successful performance of the items, but, rather, resulted in a delay in successful performance."

While a number of children failed in the various tests, Mrs. Bradway found that a good many blind adults were able to pass all of the items, which leads her to state, "Evidently, then, blindness alone does not prevent successful performance of any of the items within this range."

While Mrs. Bradway concludes that "blindness is, apparently, a greater social handicap than is deafness," we are not quite ready to admit this because we have used the social-maturity scale with our own children and have found their S. Q.'s to average 80, which compares favorably with her report for the deaf. From our point of view, the social-maturity scale has value in that it enables us to discover deficiencies in our children which may be remedied through greater attention.

While these various methods of measuring are, perhaps, outside the true field of mental hygiene, they are necessary steps in the approach to that area. Over and beyond them must be the constant study of the children in our care, combined with corrective programs and constructive influences, created through personal interviews and conferences. I wish you might know the careful records we keep of our pupils' progress and share with us the conferences devoted to the consideration of their personal and personality problems.

The necessity of developing the mental-hygiene aspect of the modern educational program for the blind has been stressed by various blind writers and educators. Perhaps the sharp rapier of Dr. Cutsforth has been thrust most deeply into the vulnerable spots of our program. While giving credit to the first director of Perkins for revolutionizing the program for the blind a hundred years ago, he points out that "since that time his successors have satisfied themselves by imitating the material achievements of that pioneer, but none has dared to go beyond what he was able to achieve . . . and they have lost sight of the blind individuals and of the fact that each pupil represents a separate and individual social problem." Samuel Gridley Howe introduced, admits Dr. Cutsforth, "a system of literary and manual training when he founded Perkins Institution. The blind were made to participate in the intellectual pursuits of their seeing brothers, and they were taught to engage in the industrial activities of their neighbors. A hundred years later the blind are still laboring, hopelessly, with their problems of personality and wrestling ineffectually with their social adjustment."

Although Dr. Cutsforth states with some positiveness that "the creative spirit in the education of the blind in America died with Samuel Gridley Howe in 1872" (it should be 1876) and "that if he should make a centennial visit to America, he would be the first to apply the torch to much of his own construction," we who carry on within the realm created by Samuel Gridley Howe find it a little difficult to believe that he would want to consign us utterly to the flames.

I have a feeling that if Dr. Howe should make the visit to Perkins to-day that Dr. Cutsforth suggests, he would greet, rather appreciatively, our present program, especially our efforts toward adequate mental hygiene. I think he would approve of our psychiatric social worker, who builds up a relationship between the family and the school, and provides us with the background upon which we must build in erecting the structure of youth. I think that he would give his blessing to the psychometric work that we are developing as a means of understanding our task and the material that we receive, and that he would approve of the psychological

work, which attempts to meet the maladjustments that blindness brings to each individual in varying scope and intensity.

I am quite certain that he would look with favor upon our clinical work in speech correction and upon our program of physiotherapy, in which we try to overcome the "blindisms" and physical manifestations of a lost sense. I am certain, also, that he would endorse the extensive program of outside activities that we are developing to keep our pupils normal and in contact with the seeing world for which they must fit themselves, and our coöperation with all the hospital and institutional resources that we have at our command for furthering the well-being of our pupils.

Month by month we meet together, those of us who are engaged in the personnel work of Perkins, at a large table in the board room, to discuss from the respective angles of our specialties the various aspects of pupils' difficulties, so that, working together, we may bring a full-rounded program of rehabilitation, guidance, and adjustment to bear upon the needs of our boys and girls. As we sit at this table and discuss their problems, there hangs above us the portrait of Samuel Gridley Howe, and I have a confident feeling that, modest and incomplete as our work is, Dr. Howe is looking down upon it with the benediction of his great personality.

In many ways his is the abiding and sustaining spirit that keeps Perkins constantly moving forward toward the attainment of its goal and the fulfillment of its aim, which has been stated to be to prepare our young people to lead poised and purposeful lives. Poised, in that they are to be kept free from the mannerisms which are often a greater handicap than defective vision; they are to be taught to stand firmly upon their feet, confident of their ability to face life squarely. Purposeful, in that they will have the conviction of a real and worth-while purpose in life. It is our responsibility to help them find that purpose. This means that we must study the traits and characteristics of each pupil, until we find out what is the best contribution that each can make to society and how we can guide each one into the most useful and satisfying life. To my mind that is our great challenge, and in meeting it we must muster all the forces that combine to form an adequate mental-hygiene program.

UNDERSTANDING THE NON-READER

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SEVERAL years ago a group of well-meaning Brooklyn citizens preferred formal charges of incompetence against a man who at the time held a high administrative city position. The specific complaint was that this gentleman could not read and write. After several hearings and protracted deliberations, the presiding judge dismissed the charges with the comment that inability to read did not necessarily reveal a defective mind, and that the man's general intelligence, his character, and his record in office established beyond any doubt his superior qualifications for the post.

Two years later an adolescent of Italian parentage was tried before a Brooklyn court for having caused an automobile accident. A mental examination was ordered, and the judge, backed by results from an intelligence test that required normal mastery of language and good reading ability, concluded that the boy was feebleminded. After this decision, the New York daily papers carried front-page articles and alarming editorials about morons being licensed to operate motor vehicles and to kill innocent citizens in the streets of New York. The chief sign of the defendant's mental deficiency, as the papers had it, was that he could not even read English because he read "was" for "saw" and "38" for "83."

More recently we have read about the New Jersey policeman who, after years of satisfactory service, lost his job when some of the townsfolk discovered that he could neither read nor write. Another prominent news item reported some time ago that reappointment of the chairman of a Pennsylvania school board was contested on the ground of illiteracy. Good common sense and superior practical abilities demonstrated in the service of the community did not compensate for the stigma of illiteracy.

Most of us will readily agree with the judge who thought that being intelligent and being able to read are somewhat independent of each other, since reading is only one of many ways of acquiring knowledge. Speech, pictures, facial mimicry, manual products, and the sign language of the deaf-mute are other forms of communicating ideas. The adoption of reading and writing as universal forms of intelligent expression is a relatively recent development. A hundred years ago the majority of people in this country could neither read nor write, either because they did not have the opportunity to learn to read and write or because they did not feel any necessity for doing so. Illiteracy may have kept them ignorant of many facts acquired through reading, but it did not necessarily make them less intelligent than we are. We might therefore conclude that such striking cases of illiteracy as those cited above are simply the remains of an age when schools were fewer, when school attendance remained on a voluntary basis, and when the flow of printer's ink was less copious than it is now.

On the other hand, we know that some people learned to read with considerable ease in less enlightened times than ours, and we also know that many people fail to learn to read in our own times when opportunities are ample and when enormous social pressure to do so is brought to bear on all, by legal sanction and unofficial ridicule. Another astonishing fact is that many children *learn* to read in spite of their school training and that many others *fail to learn* to read in spite of their school training. This makes us believe that lack of opportunity alone does not explain all that is to be known about people who cannot read in this age of cheap books, popular magazines, daily newspapers, free public schools, and libraries. One difference between the present generation and that of a hundred years ago is that nowadays many more people pretend to be able to read. Among those who pretend to, but cannot, read we find individuals of all degrees of intelligence, from moron to genius. Among good readers the range of intelligence is equally great. Thus we have morons who read much more than they are able to grasp, and mentally superior individuals who grasp much more than they are able to read.

Applied psychology has made two significant contributions to the stock of social sciences during the last fifty years—(1) the introduction of mental measurements, and (2) the discovery of the non-reader. The latter was accomplished not without some blundering, since at first those who lacked brains and those who lacked the ability to read were indiscriminately confused. The source of this confusion may be traced to attempts to interpret test findings on the basis of what we wished to measure rather than what we actually did measure. Naming a test an intelligence test was sufficient to convince its users that it measured nothing but intelligence, and selling a test under the caption reading-achievement test meant that it measured nothing but achievement in reading, even though both tests depended mainly on ability to read. When these tests were tried out on the same group of individuals, a surprisingly high agreement was found between the results attained by each individual. Those who attained high scores on the so-called intelligence test also received high scores on the reading test, and those who attained average or low scores on one test, also had average or low scores, respectively, on the other test. This high agreement led to the fallacious belief that intelligence and reading ability were one and the same thing.

But when a non-verbal intelligence test is applied to the same group of individuals, we find that many of those who attained very low scores on the reading tests, whether of the intelligence or the achievement type, attain average or even superior ratings on the manual tests. Such divergent results are interpreted by some as indicating a special mechanical genius in otherwise feebleminded persons. If we take the trouble to study the social and vocational careers of these genius-morons outside of school and the psychological laboratory, we find that their successes are out of all proportions to our pseudo-scientific predictions. Life furnishes many inexorable checks on naïve and inaccurate interpretations of statistical data. Facts gleaned from life itself indicate that the moron with special talents is an artifact. They also indicate that, in most instances, we are dealing with perfectly intelligent individuals who are unable to express their abilities by means of language because of

an inherent behavior pattern independent of intellect. This point of view is gaining an ever-widening hold among psychiatrists, psychologists, and educators. The great changes now taking place in the schools of America, which are trying to readjust teaching methods and administrative procedures to a large number of intelligent non-readers, are the first major and tangible contribution of mental hygiene to society.

We are now ready to investigate the nature of reading disability and its consequences upon the scholastic, vocational, and social careers of children afflicted with it. Let us repeat that reading is a means of communicating ideas. It is a tool of intellect, not intellect itself. Like any other system of transportation, reading has two distinct phases—(1) the building of the mechanism and (2) the operating of it. Factories build airplanes, buses, trains, and boats; transportation companies operate them to move passengers and merchandise. It is clear that building a boat and operating it are independent processes. The same is true of reading and thinking by means of reading. We can think without reading and read without thinking. The psychology of learning to read is so radically different from the psychology of thinking that the distinction between building the mechanism and operating it should always be kept clearly in mind. To learn to read, we must establish an association between the sounds of spoken language and the symbols visually perceived. Reading disability is primarily a deficiency of the mechanism. This explains why most children who cannot read are considerably more intelligent than their reading ability indicates. Their deficiency is not one of thinking in general, but one of thinking by means of reading. They may be compared to a good pilot trying to operate a defective airplane. On the other hand, the moron who reads well is comparable to a defective pilot trying to operate a perfect plane. I do not mean to imply that all non-readers are of average intelligence, nor that all morons are good readers. The number of non-readers is much larger among morons than it is among average children, and in turn is larger among average than among superior children. High intelligence helps to overcome reading difficulties more readily than low intelligence, but it does not prevent them from occurring

and causing grave adjustment problems. Furthermore, of two children with equally good intelligence, but different reading abilities, one may learn to read without apparent effort and in a short period of time, while the other may struggle along slowly and laboriously for many years.

Reading disability is not the only characteristic of the children whom, for convenience, we call non-readers. Comprehensive psychological studies reveal a complex of fairly well-defined symptoms associated with reading disability. The average non-reader is defective also in spelling and handwriting. He is usually retarded in general language development. His vocabulary is limited. All types of speech defect, such as stuttering and poor articulation, are common. His understanding of language is inferior. He is deficient in all tasks that require good directional orientation. His memory for number series and for asymmetrical drawings may be unreliable. Color designs are reproduced upside down or reversed in lateral position. Studies of pre-school children, from two to five years of age, and periodical re-examinations, seem to show that this adjustment pattern is established long before the child enters school, and that reading disability is thus predictable. The same pattern is readily identifiable in adults many years after their reading disability has been overcome. The symptom complex of non-readers points to the presence of a non-intellectual attribute in behavior which I have named the "hodotropic dimension."

Reading disability is rarely complete, particularly after several years of school training. Its degree is determined partly by the school-achievement pattern, and partly by the errors made in oral-reading tests. The school-achievement pattern of most non-readers is this: arithmetic highest, reading next, spelling lowest. An illustration of this is the case of P. M., which follows:

> P.M. is a fifteen-year-old white boy who was referred to the clinic by the juvenile court for stealing bicycles. He is in the seventh grade. His intelligence is better than average, but he shows no constructive interest in school. He has been an intermittent truant ever since he was promoted to the fourth grade. His achievement in arithmetic is at the beginning of the eighth grade; in reading, at the beginning of the fifth grade; in spelling, at the end of the third grade.

All non-readers with achievement patterns similar to the one just described make certain errors that set them off from good readers. An analysis of reading errors usually reveals the occurrence of two distinct types of error, which have their basis in the two psychological phases of reading. The primary error is, of course, one of defective mechanics, it may, therefore, be called the hodotropic error. The second type of error consists of the tendency to guess, to add words, and to supplement the context. It is an attempt to make a meaningful response and may, therefore, be called the ideotropic error. These types of error may occur simultaneously or separately. The hodotropic error is always a reversal or inversion error. It may appear in its pure form when children read "was" for "saw"; "on" for "no"; "flee" for "feel"; "that" for "what"; "how" for "who"; "on" for "not"; "pig" for "dig"; "pick" for "quick." Or it may assume the form of the addition and omission of letters and words, the skipping of lines, and the rereading of the same line.

The case of T.L., a sixteen-year-old junior-high-school boy, furnishes an excellent example of the way in which most non-readers err. His achievement in reading was just short of fourth grade. He had previously been diagnosed as feebleminded and as a poor reader because of "faulty habits and poor attention." He was otherwise a stable, mature adolescent, with a number of active interests sublimating his handicap. He was thoroughly adaptable and the type of person whom only a psychometrist could mistake for feebleminded. When asked to read from a sixth-grade history book, he made the following "careless" errors: the number "1886" was read "1898"; the word "seaport" was read for "shorter"; "saw" for "was"; "lion" for "oil"; "flayed" for "failed"; "as" for "so"; "for" for "of"; "dogged" for "dodge"; "help" for "held"; "ealest" for "castle"; "king" for "knight"; "nicksman" and "knicksman" for "kinsman."

Reading "lion" for "oil" is the result of both hodotropic and ideotropic interferences; it is primarily a reversal made meaningful by the addition of the final "n." "Calest" for "castle" and "knicksman" for "kinsman" are purely hodotropic errors. In oral and written spelling both types of error are quite common. In learning to write, the non-reader produces numerous mirror reversals or shows a preference for inverted writing. Reversal tendencies and mirror writ-

ing are neither rare nor extraordinary. Teachers of primary grades and of special classes may find evidence of their occurrence in more than 50 per cent of their children. Some overcome the initial conflicts in spatial orientation rather easily; others continue to have serious difficulties for many years. Many never overcome them fully, even though their reading may be adequate for practical purposes.

It is natural for us to display an active interest in our successful undertakings and to shun failure. Success brings confidence, satisfaction, self-respect, and incentive for more and better effort; continued frustration results in worries, self-effacement, and avoidance of unpleasant duties. After the first two years in school, the non-reader is usually a friendless child. School symbolizes all the bad things in his life. Marks, report cards, promotions, and other unfavorable comparisons are a source of constant mental anguish. They are perhaps less tangible than physical punishment, but their ultimate effect on mental health is equally devastating. By the time he is twelve years old, he has generally reached the fourth or fifth grade. He then competes, with little or dubious success, with children incomparably less mature than he is in most respects. Truancy then becomes the forerunner of more serious delinquencies. Well-intentioned parents are as helpless as the school in trying to remedy the situation and estrange him still further by arbitrary and irrelevant disciplinary measures. If the home offers no valid substitute for gang play, his only recourse is the street. There he finds, to his astonishment, companions who understand him better than his teachers, classmates, and parents. There also he perpetrates, more by accident than conscious planning, his first major offense against society.

The non-reader is a "born" mechanic. He stands for all that is concrete, worldly, real; he entertains a genuine dislike for the verbalist atmosphere of the schoolroom. His dualism is often manifest during the psychological interview. During the verbal examination he is apprehensive, withdrawn, surly, suspicious, dull, indifferent, and hopelessly bored. As soon as some manual work is introduced, his attitude changes. He then appears active, enterprising, self-reliant, accurate in judgment, planful, intelligent, and resourceful. His manual

thinking reveals him as he really is. Those who do not tap his manual abilities never learn much about him and his potentialities. To them he is just another moron. Should he in later life make a normal adjustment, he still is just an idiot-savant. The non-reader's vocational future depends on the cultural and economic status of his parents, on the treatment he receives from the hands of those in charge of his education, and on his school progress as determined chiefly by achievement in reading and in English. If his achievement in reading is at the second-grade level at the time he leaves school, he is condemned to unskilled labor and odd jobs for the rest of his life. Another alternative is the industrial school, the workhouse, or the jail. If he completes the eighth grade with fourth-grade reading, you may find him a semi-skilled laborer or a mechanic, a carpenter, a plumber, a gasoline-station attendant, a janitor, or an athlete. If sixth-grade reading helps him to graduate from high school, he may be a laboratory technician, an independent tradesman, or a baseball player. Those who have ambitious parents, some money, and seventh-grade reading ability may graduate from college. We are more likely to find them in the highly technical professions than in the philosopher's chair. It goes without saying that not all people engaged in technical vocations are non-readers.

Reading disability, as it is known to-day, was first described about one hundred and fifty years ago, when a minor German philosopher wrote about his own futile attempts to learn to read. It did not become a major social issue until the introduction of compulsory school attendance and its strict enforcement. Since the turn of the present century, hundreds of psychiatrists, neurologists, oculists, psychologists, optometrists, and educators have racked their brains in an attempt to determine its cause. Some have thought that it is due to a destruction of the brain centers in which the language functions are localized. Others have believed that it is caused by a physiological underdevelopment of the brain centers for words. Between 1900 and 1915 most psychiatrists regarded it as just another sign of general mental deficiency. Many held and still hold the view that there is something wrong with the eyes, although control experiments reveal no more

visual defects among non-readers than among good readers. Psychopathic and neuropathic constitution and emotional instability are, according to some, supposed to cause reading disability. Accurate clinical studies fail to substantiate this view in the majority of cases, even in those referred for nervousness and bad behavior. Some theorists blame reading disability on any factor they may find associated with it. Faulty habits and poor home training are responsible for it, they say. In most instances these "faulty habits" are in existence long before any attempt is made to teach the child to read and persist despite ideal training conditions. Those who study the non-reader not only in the armchair, but also in the field, know that home training is instituted only after the school fails to produce the desired results. Home training does not cause the defect, but helps to overcome it.

Another theory is that of biological variation. According to this, reading, like the color of our hair, has an independent existence and is distributed among people according to the law of chance. As we have stressed before, reading disability is not an isolated defect, but occurs in association with several other deficiencies or peculiarities. Its basis is much broader than that of a unitary mental or physical trait.

The most plausible explanation of reading difficulties is one that adheres strictly to the findings of the clinic and the laboratory. It links reading ability to the fact that our language functions are actively controlled by only one side of the brain. Reversal tendencies are explained by the failure to establish a definite dominance in either the left or the right side of the brain. Reading disability is the result of a conflict between the two sides of our body. A variation of this theory maintains that reading disability is due to a confusion that arises when a native left-sider tries to learn something that is a strictly right-sided act. That the incidence of actual and potential left-sidedness among non-readers is very great cannot be denied. Out of seventeen severe non-readers treated by the writer in the past, twelve wrote with their left hands and the remaining five showed strong left preferences in other activities. Mirror writing and hodotropic behavior is the normal mode of expression of the left-sider. The final proof that left-sidedness and reading

disability are closely associated must await the perfection of tests of laterality, actual and potential. The most valid method of studying sidedness is the ambigraph test of laterality. It consists of having children draw asymmetrical figures on an upright plate with both hands at the same time. The hand that draws the actual figure is considered dominant, the one drawing its mirror image is non-dominant.

Four years ago the writer studied 156 children in the second grade. A reading test, a non-verbal test of intelligence (Haggerty), and the ambigraph test were administered. When the incidence of left-handedness was studied according to the placement of the children in the fast, middle, and slow group in school, it was found that only 11 per cent of all the responses in the fast group were left-handed, 38 per cent of the responses in the middle group were left-handed, and 57 per cent of the responses in the slow group were left-handed. The correlation between the intelligence test and achievement in reading was .41; that between the ambigraph results and reading was .37. Both correlations were statistically significant.

Reading disability is not a specific defect. It is not a defect at all, although in some of its external manifestations it resembles one. The non-reader is characterized by an inherent behavior organization different from the one that is most conducive to a normal unfolding of our most important functions of social intercommunication. His intelligence, mental stability, and temperamental qualities are as good or bad as those of the normal reader, but the social consequences of his handicap and the direction of his mental growth are such as to simulate mental deficiency, imbalance, psychopathy, neuroticisms, and temperamental deviations.

The treatment of children with reading disabilities is chiefly a problem of education. Some private and some public schools have already tried to adjust their programs to a large number of non-readers found among their pupils. Remedial treatment of the non-reader is a most gratifying, though not an easy, task. The improvement is entirely symptomatic and does not produce any marked changes in the personality make-up. But the child does learn to read. The most important condition of success in treatment is

individual instruction. In some schools small groups of from three to five children are formed and a special teacher is assigned to instruct each group twice or three times a week, giving as much individual attention to each child as is possible. A child with a severe reading defect in a group of forty children could attend school as long as he lives without even learning to identify a few simple words. Special and ungraded classes are little more than administrative makeshifts, unless individualized instruction is given.

Any good teacher of the primary grades may be successful in tutoring the non-reader, providing she shows an understanding attitude, patience, and resourcefulness, and provided she is able to instill confidence by emphasizing success rather than failure. Most children do want to learn to read. Their interest and ambition are destroyed by lack of success. Ridicule, harsh treatment, and punishment are highly inappropriate measures for children with defects for which they are in no way responsible.

The methods of teaching the non-reader are essentially the same as those by which we all learn. They must be based on a knowledge of both phases of reading, forming a set of skills and operating these for purposes of exchanging thought. Teaching to read without reference to the very essence of language, phonetics, is like flying in an imaginary airplane. In both cases we get nowhere. One reason for the large number of non-readers who graduate from elementary and secondary schools is the exclusive use of the look-and-guess system of teaching reading. It is not advisable, however, to teach phonetics to the exclusion of meaningful material. The word-and-brief-phrase method is legitimate, if the teacher explains the left-to-right sequence and the sound-symbol associations that must be formed and mechanized before our mastery of reading mechanics is sound and complete. Applied phonetics provides the child with a dependable method of approach in the presence of unfamiliar words. It saves him the trouble of guessing from pictures and context. It does away with a great deal of the rote memory work so common nowadays. Reading for thought cannot be effective unless the motor skills underlying it have by careful training become entirely automatic. The sooner this is accom-

plished, the better children comprehend what they read. The fact that some children apparently learn to read by the guess method alone is no valid basis for assuming that phonetic learning does not take place. If reading without recourse to phonetics were at all possible, our whole system of graphic symbols would be superfluous.

Speed of reading is greatly overemphasized by most teachers. The non-reader does not react favorably to demands that he be perfect from the very start. No piano teacher would think of beginning a first lesson with difficult symphonic music and expect a fluent and meaningful performance. Yet in teaching reading we do that very thing, even at the risk of self-deception. A certain degree of quiet reflection and slow, methodical progress ultimately bring a deeper understanding of what is read than this mad rush for the best guess about the main point. In good literature the little points are as important as the main point. Present methods qualify for little more than pulp, tabloids, and "funnies."

Pictures, flashcards, and other supplementary devices used in teaching stimulate the interest of the child. They rarely stimulate the proper kind of interest, however. There are several important arguments against the use of irrelevant, wasteful, and devious procedures in individual teaching. First, there is no mental activity, no matter how meaningless, which is intrinsically uninteresting. Interest in an activity depends not on its nature or contents, but on the manner of its presentation and on our success in it. Phonetic drills can be the most delightful and helpful exercise of a remedial session, while pictures may constitute an unnecessary source of distraction. Second, the teaching situation should satisfy the demands that future life will make upon what we learn. Teaching to read symbols by way of pictures is a violation of this useful principle. Non-readers are extremely fond of looking at pictures. They do it to avoid a difficult task. The presence of pictures encourages guessing. If a picture is shown of a dog running after a boy with the phrase underneath it, "The dog runs after the boy," the average non-reader dispenses with the necessity of looking at the sentence and may "read" promptly: "The boy is going to bite the dog."

Looking at pictures interferes with proper eye movements. Picture perception differs from symbol perception in that the former requires no definite directional orientation, while the latter does. If the child's natural way of moving his eyes is from right to left, he may look at the picture in his own natural way without loss of meaning, but as he transfers to the words below or beside, he is severely penalized for using the same method of approach. There can be no objection, however, to the use of pictures for purposes of illustration.

It is believed that the act of reading occurs during pauses that the eyes make as they move along the line. From the nature of reading errors, it is obvious that the movement is as important as the pause. Photographic analogy fails to explain the dynamic aspects of the reading act.

Since reading is essentially a motor phenomenon, simultaneous exercises in writing and reading are extremely helpful in forming proper habits of left-to-right progression and in overcoming the tendency toward reversals.

Methods of instruction should be subordinated to individual assistance and a wholesome relationship between pupil and teacher. A satisfactory solution of the educational problem of helping the non-reader at an early stage will prevent a great deal of unnecessary human suffering. Many so-called behavior problems will disappear. Certain types of social maladjustment will be obviated. Above all, a great many intelligent and stable children will be enabled to work up to the level of their true mental capacities in school. Their vocational outlook will not be dimmed by the specter of a permanent handicap with an attendant inferiority complex.

A SUMMER CAMP AS AN INTEGRAL PART OF A PSYCHIATRIC CLINIC *

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FOR some years summer camps have been a part of the program of most agencies dealing with children, with the emphasis placed on improvement in physical condition. More recently, interest has broadened to include children with behavior problems. For the most part such children have been sent with some vague idea that the camp period would change the personality of the child, or at least give him a regular and supervised life away from the disrupting influences of the city.

The Psychiatric Clinic of the Massachusetts General Hospital used various resources for children who might possibly benefit by camp régime. On the whole, the results were not particularly satisfactory, although the clinic conferred with the agencies concerned preparatory to the child's going to camp and kept in touch with his progress while he was there. To be sure, many of the children did make important gains while at camp and these improvements were carried back for a time into their home life. Frequently, however, the camp, instead of being a socially constructive experience, was ineffectual, and in some cases, even added to the child's growing sense of failure. The timid child did not profit from group experience because he tended to be overlooked, while the overaggressive child was considered a nuisance. Unwittingly, problems were sometimes intensified, for, misguided by the child's interests, those in charge encouraged unwise compensations. An example of this is the girl who, though her problem was the rejection of femininity, received too much encouragement in masculine sports.

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Camps organized for the average child cannot adequately supplement the work of a psychiatric clinic. There is no definite tie-up between the clinic treatment and the camp experience, constructive though the latter may be. Some children benefit by merely being removed from unhappy environmental conditions, while in others the behavior patterns have become such an integral part of the child's personality by the time he is referred to the clinic that they would manifest themselves regardless of environmental change. For highly individualistic children with such serious problems as antisocial behavior, withdrawn personality, overconcern with health, physical symptoms of a psychogenic origin, and neurotic manifestations objectionable to others, this short period of camp is not of lasting value unless it is made a logical step in the treatment process. It was felt, however, that under the direction of the staff of a psychiatric clinic, a camp could meet this need by evolving a program based upon the specific problems of the individuals who make up the group.

Consequently, in the summer of 1935, the Psychiatric Clinic decided to take over a camp completely for a three-week period, for the benefit of a group of boys who had previously attended the clinic. The plan was to work out a program based on the needs of this particular group under the direction of the therapist, who knew each boy's problem intimately and who would be in charge of the camp. Treatment in clinic during the spring attempted to give the boys some idea of the reason for their being selected for camp and to acquaint them with the camp program as it affected them within the group. The camp was set up and maintained as an integrated society, with a recreational and non-competitive type of program. The activities included nearly all those to be found in the ordinary camp and were subject to modification in keeping with group interests and individual needs.

During the first summer sufficiently promising results were secured to warrant the establishment of a permanent camp in connection with the clinic. The length of stay was increased to four weeks for the boys, and a similar period was

planned for the girls. Interest in the project was aroused and funds were made available largely through the efforts of a financial camp committee.[1] The initial plan has been maintained—*i.e.*, only children who have been previously studied and treated in the clinic have been chosen. Particularly with young children, consideration has been given to the fact that the parent also is under treatment. The number of children has been limited to not more than twenty-four for each four-week session.

To a casual visitor at camp, the children appear as a group of average youngsters, with problems such as are found in any camp. Here, however, are concentrated a group whose problems are deeper seated and whose reactions, therefore, require more thorough understanding as well as more patience and ingenuity on the part of the camp personnel. Perhaps the outstanding problem presented by these children is their inability to coöperate with others for mutual benefit. Each is an individualist and, for the most part, disregards group activity if it does not happen to fit in with his immediate mood.

Because of the nature of the problems that arise in a camp of this type, it is desirable to have only mature counselors. Experience has shown that the average junior counselor has not the judgment or the understanding necessary for handling the situations with which the counselor in such a camp is called upon to deal. In selecting counselors, therefore, personality, rather than previous camp experience or technical knowledge, has been the deciding factor. Men and women are chosen who are interested in childrens' problems and who are themselves sufficiently free from inner tensions to create a serene atmosphere. The ideal counselor should be well enough adjusted so that he does not project his own problems into the child's behavior. He should also be able to handle the hostilities and attachments that arise in child-counselor relationships. Children such as these, who have had unsatisfactory relationships with their own parents, are more apt to show ambivalent feelings toward counselors, who are to some extent parent substitutes. It is not necessary, or

[1] Two grants were made by the John and Mary R. Markle Foundation.

probably even desirable, from the standpoint of a well-rounded staff, to have an entire corps of psychiatrically trained counselors. Frequent staff conferences, and informal talks with the therapist when problems arise, give the counselors sufficient guidance and interpretation of the child's behavior. These counselors, with their diversified interests and technical skills, can open up rich experiences to the child, particularly when they are presented in a living, dynamic way and free from the pressure for perfection.

Not all children under treatment in the clinic are considered suitable for the psychiatric camp. It would not be possible to take them all, nor in many instances would it be advisable. For some children, a summer in camp, while helpful and much appreciated by them as well as their parents, would not materially aid in the solution of their problems. Such children are not, of course, discouraged from attending other camps. In fact, the clinic helps in the selection of a suitable camp and coöperates with its personnel, so that these children will benefit as much as possible from their experiences. Some children have adequate summer programs arranged by parents. Others are much too disturbed emotionally at the time to be even considered for camp life. There is also a small group of children who could profitably go to camp, but whose parents are not yet able to let them make this break. To insist that the child be allowed to go to camp might seriously block further efforts on the part of the clinic to help the child, or might even cause the parents to terminate treatment. Other children whom we have found it advisable not to take are those with symptoms that make them appear peculiar to the other children. Such children are those with severe chorealike movements or frequent fainting attacks, and those with such withdrawn personalities that they are unable to make any kind of contact with any other child on any basis.

The first criterion for selection is that we have sufficient understanding of the child's problem to feel that the camp experience is a logical step in treatment. The second consideration, equally important, is that we shall have built up a strong enough rapport with the child so that he is able to

take advantage of camp life as it relates to his difficulties. For some children this is not a special problem, but for others—such as the timid child, the one who is unpopular with children, and the child who is in the process of emancipating himself from his parents—camp life can at times be a painful experience fraught with anxiety. However, it is one that he is able to face if he has confidence that the therapist understands him and can help him. For him, as for all the children selected for camp, treatment must have progressed to the point where he has some insight into his problems and is ready for help. Exceptions are children who need the experience of living away from the family circle in order to become aware of their problems and also those children for whom it is desired to strengthen the patient-therapist relationship through the informality of camp association. The extent to which the child understands the relation of camp to his problem depends on his age and the progress made in the clinic.

One unhappy eleven-year-old boy, unable to get along with other children, was helped to work through his problem in the clinic to the point where he realized that, by teasing and playing mean tricks on his schoolmates, he was expressing the antagonism that he felt toward his unsympathetic foster parents. Spurred by this knowledge, he was eager to overcome the traits that caused him so much unhappiness. Camp was suggested as a place where he could put into practice the more wholesome attitudes gained through his new insight and where he might also experience satisfactory group living. He was not eager to go, as past experience made him realize how difficult it would be for him to adjust to group life. He reasoned that since he had never had any satisfying relationship with any boy, it would be unbearable to have to live several weeks with boys who he was sure would not accept him. The legitimacy of this objection was not minimized. However, reassured by the therapist that he was now able to take this forward step, and that he would be helped to meet whatever unpleasant situation arose, he consented to go.

In contrast to this unpopular, aggressive boy, was an extremely timid fourteen-year-old who likewise would have

been unwilling to go to camp had it not been for his feeling of security in the therapist. This boy had had, since he was a small child, a fear of other boys and girls so severe that he was utterly miserable when thrown into social contact with them. If suddenly spoken to, his muscles would become taut and his mouth dry, and his heart would begin to pound. Although always a shy boy, during the last few months before coming to the clinic he seemed to have become even more withdrawn. Teachers complained that he was slow in responding and often did not hear what was going on in the classroom because of daydreaming. Frequently he had a silly grin on his face and "seemed a thousand miles away." Failure seemed inevitable in spite of his superior intelligence.

The distance at which this boy lived from the clinic did not permit of an intensive psychiatric study. Therefore, the mechanisms underlying his fear were never discovered. By the time camp opened, however, he was able to talk quite freely of his desire to have friends. Frequent illnesses and numerous medical examinations, because of a suspected tubercular condition, had made him feel inferior to other boys. Daydreams in which he had no physical or social limitations were much more satisfactory than reality, and the boy was beginning to lose himself in them more and more.

A few superficial, but practical suggestions, with the reassurance that physically he was not actually inferior to his classmates, encouraged him to make a gesture of being friendly with a few boys of his acquaintance. But never having included him in any of their activities, they quite naturally paid little attention to him, and the boy realized his loneliness more than ever. He was, however, willing to tackle the situation again. In camp it would not be necessary to break into a well-organized group held together by common interests and experiences, since all the boys were strangers to one another. He would, at least at first, be accepted by the other campers and would, of course, be included in all the camp activities.

He understood that he would probably be homesick at first. He also realized that his tendency to withdraw from contact with other boys would be a serious handicap in learning

group living unless he made a conscious effort to participate. He would not be expected to take part in games that depended upon highly organized skill—such as baseball, which he had never learned to play—but would be expected to enter into all other camp activities, regardless of the fact that this would not be easy for him. The boy accepted camp on this basis, although, to be sure, with many misgivings.

Children who seem to benefit particularly from this type of individual and group treatment may be roughly classified as follows:

1. Children for whom therapy consists mainly of habit training and for whom camp affords an opportunity for inculcating and strengthening the new patterns.

2. Children whose problems center around unsatisfactory relationships with other people. In such instances practice in group living is necessary to help the child make the modifications and adjustments suggested by the clinical study.

3. Children who are too closely attached to one or more individuals in the home and who need camp life to help them become more self-reliant and independent.

4. Children whom it is desirable to observe twenty-four hours a day in a variety of situations, in order that a clearer formulation of their problems may be made.

5. Children who need the camp experience to make them more aware of their problems and to help them understand how environmental factors are contributing to their difficulties.

6. Children who need the camp experience as a means of strengthening their relationship with the therapist for further progress in treatment.

Treatment, as it is planned in camp, is designed to meet the needs of the individual, but is carried out largely through group activities, since the function of the camp is to provide socially constructive experiences under controlled environmental conditions. There are certain advantages that naturally accrue from well-planned group living. But in a psychiatric camp recognized assets can be utilized because of the comprehensive knowledge of the child's personality and background. The process of learning to live together is

not easy for these children and cannot be carried out by throwing them into group situations with a "sink or swim" attitude. Often it is necessary to grade the steps in socialization, and it is important to know how much the child is able to assimilate from the various group experiences. To push a child too fast into situations with which he is not ready to cope, or to be totally indifferent to his non-participation in group events, are equally harmful procedures. The approbation or the disapproval of the group is a powerful determiner of behavior for some children and, when brought into play under the supervision of the staff, can sometimes accomplish more in the way of creating desirable modes of behavior than hours of discussion in the psychiatric clinic.

The program is planned so that many situations arise in which the child finds not only that it is necessary to subordinate his immediate desire to conform to the wishes of the group, but that, through coöperation, his own happiness is increased. This, of course, requires judicious handling of the too aggressive child who might usurp the opportunities of the less aggressive or weaker child, and of those individuals who are inclined to submit too passively to the dictates of those who are stronger. When to overlook, when to disapprove of, or when to encourage certain behavior patterns must be determined on the basis of an intimate knowledge of each child's needs and drives.

Every child finds that he has certain daily responsibilities in the mechanics of running the camp. There is wood to be sawed and brought in; animals must be cared for, vegetables prepared, tables set, and, later, dishes cleared and washed, as well as tents taken care of and camp grounds policed. When coöperatively done, these duties take comparatively little time. The children are prepared for this work when the camp activities are discussed with them in the clinic, being told quite frankly that it is financially necessary.

There are as few rules and regulations as possible—that is, only those that are necessary for the health, safety, and comfort of all. In so far as possible, the restrictions are explained to each child before he goes to camp, so that he will understand the reasons back of them. The regulations necessary are rigidly enforced, and infractions of them bring

swift punishment, such as the denial of some activity of which the child is especially fond, or the imposition of some chore that he dislikes, or segregation. Children understand and appreciate sensible standards and gain a sense of security from adults who enforce such standards impartially and unemotionally. Group pressure may be used effectively at times, by punishing a whole group who permit one individual to do something that is dangerous or that interferes with common good. Certain children whose unconscious need for punishment is strong deliberately set out to win the enmity of the others or break rules, knowing that this will bring punishment. One must be careful lest one play up to the desires of such children, since it only intensifies their problem. One boy, after two weeks of unsuccessful attempts to be physically punished, finally complained disgustedly that the staff did not know how to manage children—that in a camp he had attended previously they really knew how to make boys behave: "Why, nearly every day the counselors had to line up and put me through the 'hot oven'."

Formal interviews with the children are not attempted while they are in camp except when it seems necessary for some special reason or when a child indicates that he would like to discuss some problem. The therapist can give direct help in resocialization by spontaneously conveying his approval or disapproval of behavior through his attitude as shown by facial expression and bodily tension as well as by a word or two spoken unobtrusively at the proper moment. This is especially true with those children who are consciously attempting to overcome some disagreeable personality trait the psychological mechanisms of which they at least partially understand. The child can accept this direct help because sessions in the clinic have created a mutual bond of understanding and appreciation between him and the therapist.

The two boys whose cases have been cited illustrate the method of direct help. The aggressive eleven-year-old boy, once in camp and faced with the social situations there, reacted by the same obnoxious behavior that had made him so unpopular with his classmates. He made himself heartily disliked by teasing and threatening to tell the counselors of misconduct on the part of other children. He had many

emotional upsets which ended in crying and in demands that he be allowed to go home. These were usually the result of teasing on the part of the other children as retribution for something he had done to them. During these emotional storms, his insecurity and the realization that their dislike was brought about by his own behavior became more apparent to him. The therapist took advantage of these upheavals to sit down with him and discuss the situation calmly. At other times when he was showing behavior that was annoying to the other boys, he was quietly called from the group and his actions pointed out. He appreciated this help and it was evident that he was genuinely attempting to alter his behavior. During the last week in camp, a decided improvement was noticed; he became more sociable and self-reliant, less frequently seeking the attention of staff members. The other boys had begun to accept him to a certain extent, but unfortunately the bad impression he had made on them at the beginning of camp could not be completely forgotten.

The timid fourteen-year-old boy, as the therapist had anticipated, was quite homesick, but grimly decided to stay until the end. At first, considerable urging was necessary to get him to participate in any group project. Gradually, however, he was drawn more and more from the fringe of the group into the center of activity. As he grew more at ease, his conversation became more relaxed, until finally he was joking freely with campers and staff. In fact, had not the staff been made aware of this boy's need for such expression, they might have been offended at the frankness of his jibes. Finding security in the fact that the other boys and the counselors were accepting him, and gaining confidence in his physical abilities because of the rapid progress he was making in learning to swim, this boy was able to express unconscious hostility through these jibes—a healthy sign and one that in his case it would have been unwise to discourage.

Besides various group activities, projects can be designed or situations taken advantage of that will help individual children in various stages of their psychological growth. The child can be given opportunities to fulfill both conscious and unconscious needs. In so far as is possible, children are

allowed to pursue special interests. For some, it is desirable to assign projects for which they have full responsibility, such as taking care of certain animals, or the construction of a pier or some other needed addition to the camp. One boy found satisfaction in making a path through the woods to an interesting spot; another boy found a desirable outlet for pent-up aggressions through the tearing down and breaking up of an old float and diving tower. Dramatics, formal and impromptu, offer a field for those children who are so inhibited that only by stepping out of their own personalities are they free for emotional expression. Of course, the too fearful and emotionally repressed child is not able to free himself even through this medium, and to attempt to force him to take part would only tend to drive him farther back into himself. Careful consideration of the sensitivity of these children can often give them a sense of security that encourages emotional expression.

Sometimes a child may be reached through being helped to develop leadership. Experience has shown that antisocial children often have excellent potentialities for constructive leadership which are dormant because of emotional problems. Such an individual was a fifteen-year-old boy whose major problem was an apparent lack of interest in the usual boyhood activities in athletics, school, and work. He had few friends, although he was not unpopular. Clinical study brought out the fact that his inactivity seemed to be the result of unfavorable comparison made unintentionally by his family between him and an older, more successful brother. Continual reference to his brother's cleverness had convinced him that it was utterly futile for him to attempt anything. For the first two weeks at camp he was disagreeable and antagonistic to the counselors. He spent considerable time lying on his bed condemning and criticizing the program. He would tease his tent mates by telling them that they were foolish to comply with the requests of the staff. He was interested in only a few events—in swimming, crafts, and occasionally baseball. It was finally noticed that the smaller children frequently turned to him for help when the craft instructor was busy and that he always seemed willing to help them. Recognition of this ability and of his willing-

ness to teach was given him by approbation and by suggesting that he become assistant to the instructor. It was pointed out to him that it would, of course, be desirable if he would use his influence to help along other activities, even though he himself was not particularly interested. From that time on, his change in behavior was phenomenal. His influence became constructive rather than destructive. Through camp he gained confidence in his own ability in a much more vital way than could have been attained by hours of discussion in the clinic. This experience was followed up in clinic by helping him to understand the reasons for his change of attitude at camp and how they might help him in making further progress.

We conclude this paper with two cases that show in more detail the integration of the clinic and the camp treatment.

Ruth, seventeen years of age, was brought by her mother to the clinic with the complaint of difficulty in reading, inability to see, general nervousness when talking, shortness of breath which prevented her from venturing out of the house, irritability, sleeplessness, fear of being alone, and uncontrolled stubbornness. At times the girl seemed to be out of contact with reality. For example, her mother told of placing frozen laundry in front of the fire to thaw out and of the girl sitting with her feet on the stove fender, letting the laundry burn. She spent the greater part of her time sitting in a rocking chair, pampered by the family group because of her physical symptoms.

The physical findings were essentially negative and it was believed that the girl's complaints were on a psychoneurotic basis. Because of the distance at which the family lived from the clinic, and because of the fact that overprotection and sibling rivalry were becoming more apparent in the family relationships, a foster-home placement was arranged and treatment was undertaken.

Treatment was explained to Ruth as an opportunity for her to talk over past experiences as they related to her problems. She soon learned how to use the interviews to her advantage, and as the therapist gained insight into the relationships of her early experiences to her present symptoms, interpretations were made to her. She was encouraged

to come back and forth to the clinic alone, and membership in a sewing group and Y.W.C.A. activities were provided. The development of normal social contacts through the community and the church was left to the foster family.

As treatment progressed, Ruth was amazed at the important part that early play activities and interpersonal family relationships and contacts played in her present symptoms. She began to understand how her inability to meet social situations went back to childhood fears. The antagonism that she felt toward her sister because of her attractiveness, her success in school, and her popularity with boys, was brought out and evaluated as a phase of development. Ruth's feelings of inadequacy had been increased by the fact that both her grandmother and her mother were mainstays in their families, while her father—who, incidentally, had never learned to read—was considered a failure by the girl, who identified herself with him.

The girl's one interest was sewing, and she soon was making very attractive dresses, gaining her first feeling of security in this way. Fortunately, the daughter in the foster home was less attractive and popular with boys, and this gave Ruth an added security. An understanding foster mother helped her to become a part of the family group by allowing her to assimilate interests and responsibilities gradually, instead of forcing them upon her.

The clinic decided that camp was the next step in treatment. Ruth was not enthusiastic about it, but consented to go. For the first few days at camp, she felt that the therapist had "pulled a mean trick" on her. However, it had been anticipated that she would have difficulty with personal relationships in the new setting and it was planned that she should not be placed in any conspicuous situation, such as reading or story-telling, but be allowed to make her adjustment in crafts. In a short time she was assisting in craft instruction. She formed an emotional attachment to the male counselor in charge, which was a constructive experience for her both because of his wise handling of the situation and because of his approbation of her skill. She began to take an interest in sports, and by the close of the camp session was swimming with little or no difficulty in breathing.

Through her teaching experience at camp, she gained a feeling that "if she could teach, she could learn." At this stage of the girl's emotional development, such an opportunity could have been supplied in no other way than through the camp set-up.

On her return from camp, Ruth expressed a desire to reënter school. She had lost her fear of reading and believed that she could do school work as well as her sister. In order that she might not meet with too much discouragement, arrangements were made with the school for her to participate in recitations only on her own initiative. Meantime some tutoring in reading was done in the clinic. On the completion of the first month, Ruth had a satisfactory report card. She was happy over her accomplishment, believing that she could now attack more difficult situations. Arrangements were made for her to attend a part-time private sewing school, where satisfactory progress resulted. Contacts with the clinic were maintained, with the understanding that Ruth was to return to camp the following summer, since she needed further relationship with a large group of girls.

After her return from camp in the fall of 1937, the girl was enrolled as a regular, full-time pupil in the sewing school, since the director had reported marked ability and suppleness in her handling of the needle. She continued to live with the foster family.

At the present time she is doing extra sewing in school to pay for a course in designing. She has been symptom-free for a period of a year and has matured personally and intellectually. Treatment at the clinic has been terminated, but the girl returns when situations arise that need further explanation. She seldom asks for advice, but prefers, as she says, "to talk out loud about what is troubling me."

Jimmie, a thirteen-year-old boy, was referred two months before the opening of camp, because he was pulling out his hair, eyelashes, and eyebrows, and in addition was troubled with nocturnal enuresis. Despite an I.Q. of 104, he was having difficulty in some of his school subjects. He was the smaller, but more intelligent of twins. Two older sisters and an older, more attractive brother, the mother's favorite, had made satisfactory school and work adjustments. There was

considerable sex play with his twin brother, with complete rejection and hatred in their social relationships. Both boys, however, were members of the same gang, which obtained satisfaction out of sex play, stealing, truancy, and upsetting school routine. The twin brother had been readily accepted by the gang, while Jimmie, because of his inability to run fast when they became involved in stealing, was not fully accepted. Furthermore, his apprehension about being caught prevented him from entering whole-heartedly into their activities.

Camp offered an opportunity to observe what situations provoked his symptoms. It was noticed that he pulled his hair with a regular ritual whenever he was excited or preoccupied. He wet the bed once during camp. This was when he was in a tent with older boys where he found it difficult to hold his own. Removal to a tent with a group of his own age prevented recurrence.

After his return from camp, therapy was continued, bringing further understanding of how the family situation was contributing to the boy's problem—particularly to his school failure. Neither his twin nor the older brother had any interest in academic attainment. The twin, who was of borderline intelligence, had been adjusted to a special program, while the older brother was taking a commercial course which the family considered second-rate as contrasted with Jimmie's college-entrance course. He felt that whatever family status he had was on this basis. For this reason he must continue Latin and French at all costs. The girls had satisfied the family's ambitions by their good school work, and he felt that he could create a similar situation for the boys.

At the same time, considerable attention was given to his need for attempting to gain the recognition of his gang. One hope of weaning him from this group, in which he was a mere tool, was to give him an opportunity for constructive leadership in the camp. He was anxious to return, since the previous summer had given him some indication of the place he could make for himself in an acceptable social group because of certain personable qualities that he possessed.

In camp during the second summer it was evident that he

had not yet progressed far enough to permit of leadership, the potentialities for which we felt he had. There were frequent outbursts of hysterical behavior, characterized by loud laughter, gesticulations, and a rapid flow of language. There was, however, apparently no loss of contact with reality nor was his behavior so peculiar as to set him apart from the group. Hair-pulling was noticed but once or twice, and that when he was under emotional strain. He was reliable in his work and well liked by counselors and campers.

By the time he returned to school in the fall, he had himself made the decision to drop algebra and Latin, substituting for them commercial courses. The parents did not fully approve, but he worked it through with them and made arrangements with the school. As he gained insight into the relationship between his sex activities, his stealing, and his hair-pulling, there was marked improvement in the symptoms. For a period he over-reacted, staying completely away from the gang and playing with small children. His ambition at one time was for a political job, and the study and observation of city government gave him real satisfaction. However, his earning capacity found expression in the excellent gardening work he did in the community. For a number of years he had been earning his own clothing and spending money.

The boy returned a third year to camp. During the year he had grown sufficiently to be able, under camp guidance and supervision, to assume real leadership. He held the respect of both younger and older boys. This respect was gained partially through physical ability, though much of it was the result of sheer generalship. Although his abilities as a leader were for the most part turned in a constructive direction, he was on one occasion the instigator of a none-too-serious after-taps fracas. There was much less evidence of the hysterical behavior noted than during the previous camp session nor was he observed to pull his hair. He wet the bed several times.

The boy is now in his third year in high school, is participating in numerous activities, and his personal appearance has improved because of a fine head of hair. However, his eyebrows still show traces of his old symptoms. He is still under treatment at the clinic, although not as intensively as before.

MENTAL HYGIENE AT SENESCENCE *

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THE study of senescence consists of two phases: first, an investigation of the mental abilities of old people; second, a study of their emotional lives. To consider both phases here would make this paper unduly long. I shall, therefore, confine it to the psychiatric and sociological aspects of old age, or, as we might say, to the mental hygiene of senescence.

A paper as brief as this cannot hope to deal adequately with all the issues involved in even so limited a portion of the field. There are enormous difficulties in the way of planning and carrying out a research program in the mental hygiene of old age. The first difficulty is that of working out a program that is satisfactory simply from the viewpoint of scientific method. Another serious obstacle is the indifference to the importance of the problem shared equally by governmental officials, professional workers, and the general lay public. This indifference phrases itself somewhat as follows: "Why should we study old people? They cannot be helped, even if we wanted to help them, and why should we want to?" The greatest hurdle to surmount, however, will be that of translating exact knowledge—when we get it—into social services. To overcome the very considerable cultural lag of this country as regards the mental welfare of the aged will not be easy. Of the total problem of mental hygiene at senescence, therefore, no more can be done here than to single out a few high lights for consideration.

We know very much less about old age than we do about any other life period. On another occasion, in making a survey of the research done in the field of mental ability at senescence, I pointed out how few and how far from adequate are the

* Presented before the Section on Care of the Aged of the Welfare Council, New York City, April 28, 1938.

psychometric investigations currently available.[1] However, psychiatric and sociological studies are even fewer and less satisfactory. Surprising as it may seem, to my best knowledge there does not exist to-day in psychiatric literature a single systematic, intensive first-hand study of the emotional problems or the personalities of old people; nor has any sociologist investigated with real thoroughness such matters as the effect on old people of tradition and convention, of economic insecurity, or of life in urban centers as opposed to that of villages and small towns. What few writings there have been by professional and lay persons hardly satisfy modern canons of scientific procedure. Hall's volume, *Senescence,* which appeared in 1922, is an armchair performance based on the results of a questionnaire given to a special group of senescents. *Mental Hygiene in Old Age,* a pamphlet put out in 1937 by the Family Welfare Association of America, contains six papers by trained persons who have had direct contact with the aged or the aging. But while this pamphlet is very valuable as a contribution to a field still largely unworked, it is not a piece of experimental research, nor does it consider the full scope of the problem or of the scientific study and social planning that lie ahead of us.

Whatever definite knowledge we have of old people is based on pathological material. Yet of the various chapters in a psychiatric text it is the one on the mental diseases of old age that suffers from the greatest paucity of judgments based on experimental evidence. So far as I know, there are only two psychiatrists in this country who devote a considerable portion of their time to the treatment of persons over sixty. For many years now, there has been a guidance clinic for the aged in San Francisco. While there has been talk of establishing a similar one in New York, no definite step in this direction has as yet been taken.

Few psychiatrists and even fewer psychoanalysts will undertake the treatment of a person over forty-five or fifty since it is generally felt by the profession that the likelihood

[1] See "Mental Ability at Senescence, a Survey of Present-day Research," by George Lawton. *Journal of Applied Psychology,* Vol. 22, pp. 607–19, December, 1938.

of a positive response to psychotherapy is very slight after this age. This may be true, of course, but any such rejection of persons past fifty, to be reliable, should be confirmed by an investigation of therapeutic successes and failures in relationship to age.

Of non-psychotic old people, we possess very little information. For example, no study has been made of what happens to neuroses as people reach an advanced age. Nor has any one investigated the psychological problems of old people who are fairly adequate mentally and emotionally. In fact, we are unable to-day to distinguish with real accuracy between an adequate and an inadequate old person or between normal and pathological mental and emotional decline. We do not know what the average old person can or cannot do, or what his interests are. For this reason, we are at a total loss when it comes to planning work or recreational programs for the aged. We must conclude that there is no phase of the lives of old people for which we are able to draw up a list of criteria for adjustment or maladjustment, normality or deviation. Indeed, who of us would be bold enough to hazard an answer to the simplest and most fundamental question of all: How "old" is an old person? It is only for the purposes of this discussion that sixty is arbitrarily selected as the dividing line between later maturity and the onset of old age proper. But when I talked recently to a man of sixty-seven about this very difficulty, he answered, "Why, I should say that late maturity extended to seventy. After *that,* we begin to grow old." So you see that even sixty is only a guess!

We have learned to look upon each child as an individual who, despite his many resemblances to other children of his own age, differs from them in so many ways that as a personality he is a unique creature requiring patient study. We also know that although relatively few children may be justly designated as problem children, all children have problems. We should adopt the same attitude toward men and women of all age levels, including the senescent.

If we divide the traditional threescore-and-ten life span into seven decades, we find that individuals in each decade have their own characteristic adjustments to make. Each period has its own pleasures and pains, its own responsibilities

and hazards, its own assets and liabilities. While we know a good deal about growing into life—that is, childhood and adolescence—we know very little about aging or growing out of life. Any study of aging will have to determine what types of adjustment individuals in our culture are called upon to make in each age decade as they pass from forty to eighty, and what situations cause emotional conflict and anxiety. When this has been accomplished, it will then be necessary, through social planning and individual therapy, to help old people in the solution of their difficulties. Since the number of persons above sixty is constantly on the increase, and since the social-economic factors which make for maladjustment at all age levels and especially at later maturity are also on the increase, the problem of what old people need in order to be happy will concern us more and more.

The psychological difficulties that aged people present can be divided into several categories, as follows:

1. The problems of neurotic, border-line psychotic, psychotic, feebleminded, and deteriorated individuals. A young neurotic, for example, if he lives long enough and is not cured by life or by psychotherapy, becomes an old neurotic. His behavior is not to be taken as typical of normal old age. Mental illness in this category is theoretically preventable or removable through individual and social therapy.

2. The minor maladjustments of fairly adequate old people caused by excessive economic pressures and inhibitory social attitudes. Here, too, behavior irregularities cannot be looked upon as part of the aging process. Such lesser mental disturbances may be mitigated through the relaxation of the pressures and inhibitions that cause them.

3. The stresses and strains of those individuals who are undergoing normal mental and emotional decline. These adjustments are intrinsic to the aging process itself. We do not all decline at the same rate in the same capacities. Though we may be born more or less equal, we do not die equal, for aging proceeds at a different tempo in every one of us. If we live long enough, we must all witness a lessening of our powers. Life may begin at forty. It may, for all we know, even begin at fifty or sixty. But eventually we reach an

age at which life stops beginning and must start, at least, ending.

I should now like to consider in turn two specific areas of adjustment which are constant in the human animal from the cradle to the grave—that of social approval and that of love.

The child who lacks social approval, or who thinks he lacks it, becomes insecure and psychologically dependent. Such a child will use various devices—tantrums, complaints, aggression, for example—in order to assert his power and control the behavior of those about him. If he cannot get approval through fair means, he will use unfair or anti-social means.

In adolescence, the chief problem for young people is that of achieving status as independent adults. They want to prove to the world their significance as socially useful and responsible men and women. In order to achieve adulthood, adolescents must oppose the attempts of parents and other grown-ups to keep them dependent.

The chief area of adjustment for adults is their struggle to discharge adequately the social responsibilities of maturity. When the former child himself grows up and becomes a parent, he faces another inevitable struggle with his own parents, now grandparents, a struggle that is really a continuation of the first one.

The conflicts of grandparents and older people generally arise out of their battle to retain the social usefulness and significance of maturity in the face of a veritable onslaught of influences threatening to batter down their former status. As we grow older, the opportunities for activity in business, the family, sex, friendships, play, all diminish. As doubt is cast over our feeling of belonging, of still being socially useful, we may become insecure and psychologically dependent, and in a fashion analogous to the behavior of the child, we may employ complaints, aggression, illness, tantrums, as attempts to gain illicitly something that we are not willing or not able to secure in a socially approved way.

Parents who become grandparents face a serious diminution of their power. If they were unable to yield gracefully as parents, they find it even harder to do so as grandparents.

It is in this manner that problem parents become problem grandparents. The "mother-in-law" who gives trouble is an individual who is failing to make the necessary readjustment of rôles called for in the fourth and fifth decades of life.

These conflicts or struggles for power between the generations—between children and adults, on the one hand; between adults and older people, on the other—are inevitable tensions in any society, though they can be very valuable educational experiences when enlightened and emotionally free individuals are involved. We ought not, however, to make them worse than civilization has already done. And that is precisely what our form of socio-economic organization is doing. Our cultural pattern aggravates the conflict between the generations by intensifying and prolonging tremendously the dependence of grown young people and by causing the dependence and social impotence of older men and women who are as yet functioning at the height of their powers.

It would seem that our life, as self-sufficient contributors to the social weal, is a candle that is being burned at both ends. If we cannot begin earning a living and rearing a family until twenty-five or thirty and then must abandon the economic arena at forty or thereabouts, the years of maximum significance are indeed becoming fewer and fewer.

American civilization is still permeated by the frontier psychology, with its notions of individualistic economic aggressiveness summed up in the "swim or sink" credo. Every individual is thrust into the world to compete as best he can with his fellows. Whatever he can obtain through his own efforts and for himself is his own, and no questions asked. He who cannot compete and survive must go under without whining. Our frontier psychology is one cause of the great amount of criminal activity in this country. It is also the reason why we worship youth and dread old age. An age phobia is necessarily part and parcel of an economy that preaches competition instead of coöperation. We have been taught to believe that if a person cannot secure employment after forty, it means he is old and should be scrapped, since we hold economic and social usefulness to be identical. The old—here forty is apparently the critical point—themselves believe it. It means little that whatever studies we have of

the mental abilities of the older worker show that in many instances he can turn out just as good a performance on the job as he ever did. Again, what we need and what is as yet not available, so far as I know, is a thorough study of work efficiency and inefficiency in relationship to age.

While I do not believe that there is any such thing as an unemployment neurosis, unemployment does intensify and reactivate an existent neurosis. Economic insecurity is a cause of great anxiety in older people, partly because of the sheer material distress it causes, but even more because unemployment and the lack of money signify to them and to others a loss of prestige and of social usefulness. And old people, in order to be thoroughly happy, need to function in normal social relationships as long as they live. It would be interesting in this connection to determine whether, as one might suppose, groups of old persons in small towns and villages are more contented than comparable groups in large cities, because of the greater opportunity in the smaller communities for securing social approval in legitimate ways.

We may be willing to grant the need of older persons for continued participation in the social group. We are much less likely, however, to admit that they have sex and love needs. Our difficulty here is tied up with the fact that we still think of old people as we used to think of women and children—namely, that they are devoid of sexual interests or desires except in pathological instances. But the thoughts and actions of old people in this sphere are not abnormal if they were not abnormal in earlier life periods. While the notion of infantile sexuality is a psychological commonplace to-day, and while the sex needs and desires of women are regarded as being as strong as those of men, though the manifestations are different, we still think of persons in later maturity (past forty? fifty? sixty?) as having lost all sexual and affectional interests and capacities.

This may be true. Nevertheless, it is also true that of no phase of the lives of old people are we more ignorant than of their sex and love needs. We do not know what they really think or feel, nor do they, for that matter. For the sex repression of American culture, so pronounced at earlier age levels, is especially strong at the senescent level. Many old

people have fully accepted the view that any sexual thoughts they may have are quite improper, if not obscene, and that sexual activity, even when socially feasible, is not to be engaged in. But old people are still adult men and women. They have not become psychologically disfranchised with the years. Should they wish to continue having sex and love experiences and relationships, that is entirely their own affair. If they have not yet reached years of discretion and self-determination, they never will. To secure the emotional independence of the aged, we will, on the one hand, have to foster, through the necessary economic security, normal relationships between the sexes to the very end of life, and on the other, do what we can to weaken the powerful and ever-present sex taboos.

We all have at one time or another reflected on the great interest that man has shown in methods of prolonging his life. Some of us also may have felt that it is more important to accept the present life span for what it is and to make its years more secure, abundant, and happy rather than to lengthen it. "Quality, not duration," we have taken as our motto. It would seem that the attempt to prolong lives that are already fraught with anxiety, already empty and bitter, is just another of the ironic contradictions of human behavior.

Any such analysis of our interest in the techniques of longevity is entirely too elementary. For what man seeks truly is a fountain of youth, whether obtained through elixirs, diets, gland therapy, or pacts with the devil. Man does not want to live longer in the sense of perpetuating decline; he wants suddenly to reverse the life process. He wants to turn back the hands of the clock and find himself again at a time when he functioned at the maximum of his powers; he wants his mature years once more. In some cultures old age is worshiped, perhaps overvalued, we would say. In other cultures, ours for example, in which we go to the extreme of undervaluation, it is looked upon as an affliction. Indeed, in this country, those of us who have been unfortunate enough to live too long are penalized on that account. Perhaps the neurotic fear of old age we encounter so often among the middle-aged will lessen when it is no longer economically dangerous for us to grow old.

It was stated earlier that as we pass from middle to late maturity, we find ourselves being deprived of more and more of the activities and satisfactions that filled our lives earlier. These deprivations, however, are not solely the inevitable concomitants of aging, but of the way our society treats aging. The tribulations of old age are as much sociological as they are biological, perhaps even more so. Many of the so-called disagreeable traits of old people and of the tragic aspects of aging are the results of the kind of civilization we have built up in this country.

The state has an obligation to make life for all types of human beings as safe and as rewarding as possible. This obligation includes not only those who are mentally, physically, and socially normal, but the deviates as well. It includes women as well as men, unemployed as well as employed persons, minority races and creeds as well as dominant ones, and finally the nonagenarian as well as the infant. The state should do this not merely for humanitarian reasons, but for selfish ones as well. Every person has some contribution to make to the social group. He can be useful, if only in a simple and limited way. The state should utilize the social and economic usefulness of all its human resources to the maximum. The aged have a contribution to make to the world in which they live. Just what it is, we cannot say at the present time with any degree of exactness. But that it is considerable and valuable, I am sure.

We should offer old age, not veneration, or indifference, or sentimental pity; we should offer it understanding based on facts. It is easy enough to grow maudlin over old people and to feel sorry for them and for ourselves who must grow old. It is even easier for us to force premature dependence on men and women, and then, when they are helpless, take care of them in a fit of zealous good-Samaritanism. I think that the greatest service we can render old age and ourselves is to study it with scientific detachment and then enforce whatever recommendations are called for by such a study.

A thorough attack on the problem of aging in its mental-hygiene aspects must include at least the following steps:

1. Intensive, systematic studies over long periods of time should be made of the mental abilities, the interests, the

recreational activities, the personalities, and the emotional problems of large groups of men and women in each decade from forty to eighty. These groups should include individuals both in urban and in rural environments, and those who are adequate as well as those who are inadequate mentally, emotionally, and physically. Such studies should be conducted by psychologists, psychiatrists, physicians, and sociologists in individual and collective research programs.

2. When we have facts about old people and not before, old-age guidance clinics should be set up to handle the problems of senescents, such clinics to function in a fashion analogous to that of present-day child-guidance bureaus.

3. When the first two steps have been taken, perhaps individual psychologists and psychiatrists will begin to include senescents in their practice. At this point, we will begin securing data on the possibilities of therapy for the aged.

4. Courses in geriatrics, utilizing the facts revealed by research workers and clinicians, should be established in the medical schools. This will equip future physicians better to understand the effects of mental attitudes on the bodily ailments of aged patients.

5. Social planning and change will be necessary in order to effect any lasting reduction in the maladjustments of old people. Every human being has the right to be usefully engaged in normal social and economic activities, if physically able, as long as he lives. When the usual work program is impossible for reasons tied up with physical and mental efficiency, then a modified work program is in order. These are the best solutions. However, the next best is retirement on savings or an annuity provided for by the individual himself or—where this is not possible, which is generally the case—retirement on an old-age pension. Some people do not fare well if they are inactive, even though they may be economically secure. Such persons should be encouraged through adult-education programs to use their leisure time for recreations and hobbies which will involve them in normal social relationships.

6. Through educational programs in the schools and colleges and elsewhere, young people and adults will be prepared for

the problems that they will face as they grow older. They will also have greater understanding of the old persons with whom they come in contact—grandparents, teachers, employers, and so on. Finally, adult-education programs will teach old people something about themselves. The greatest gift we can bring old age is self-knowledge and through that emotional freedom.

There is no group of persons whose mental welfare is more neglected than that of old people. This neglect is world wide. Even those countries that are reputedly the most advanced in respect to social services generally consider old-age pensions a sufficient solution of the problem. It may very well be that the United States will be the leader in the new science of geriatrics. And while we are still only on the threshold of this new science, at least we have a plan of action. This plan is fundamentally a call for facts and the abandonment of hearsay information and sentimentality.

MENTAL HYGIENE AND FRESHMAN COUNSELING *

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YOU have the job of helping to supervise the adjustment of Yale freshmen to the college environment. That adjustment involves more than choosing courses and friends, going out for a team, and planning a daily schedule. It is a complicated process, wherein maturing and developing individuals seek comfortable and productive *rapprochement* with their environment. People of student age are usually in the middle of the process of growing up. Their job is to work toward the independent status of adults in their relations with their families, their work, and the world they live in. Supervising the early part of this process will mean that you will observe and perhaps be asked to aid in solving some emotional difficulties. You will find, I think, that family matters, social difficulties, problems connected with the impulsive life are essentially part of the individual's whole experience, and that any job that concerns itself with student development must concern itself with these topics as well. You will, therefore, have some measure of responsibility for the emotional lives of the freshmen. Probably most of you have never before had any such responsibility. The experience should be instructive both for you and for the freshmen.

I have been asked to talk to you about your job because, as a member of the Division of Student Mental Hygiene, I have been doing work of a somewhat comparable kind here for twelve years. I hope that the experience of this department can help you in your work as counselors. I know that you can help us. I feel sure that we can profitably work together in studying and understanding student problems.

*A talk to the Freshman Counselors of Yale University, New Haven, October 12, 1938.

This talk, then, has a double purpose—namely, to describe to you the mental-hygiene service at Yale University and how it functions; and to discuss with you the kinds of problem you may expect to meet in the course of your activities as counselors. We want to make clear at the beginning that we don't know all the answers—we haven't any magic formulas—but we are studying Yale and its students, and trying to learn about the situations that arise during the college experience and that may cause difficulty in the lives of individuals.

The Division of Student Mental Hygiene functions as part of the Department of University Health. From this neutral place in the university society, the psychiatrist can address himself to all kinds of problem, physical as well as emotional, and the student is free to consult him as a professional man who is not connected with any of the administrative offices and who will preserve the confidences entrusted to him.

Perhaps the best way to introduce you to the department is to describe its activity during the past year. During the period from September to June, 200 students from all parts of the university were treated, a variety of problems being represented. About one-third voluntarily sought the aid of the department— that is, these students were up against some difficulty that they could not handle alone and decided on their own to come to us. Another third were referred by physicians in the health department who recognized the existence of definite emotional problems or found no physiological cause for certain physical upsets, such as high blood pressure, gastrointestinal distress, migraine, and insomnia, and felt that *perhaps* there was an emotional basis for the discomfort. The remaining one-third were sent to the department by parents, other patients, members of the faculty, class officers, counselors, and other members of the university who came into personal contact with them.

Many people will think that these boys were sent to the psychiatrist because they were abnormal—or just plain "nuts." As a matter of fact, the boys we see are ordinary students who are facing more or less ordinary difficulties. Some have scholastic problems, some are socially ill at ease at Yale, some are oppressed by too much parental attention, some feel the need of more parental attention. A study of

this department's first ten years' experience in treating students has revealed that 50 per cent of all the freshmen students seen had scholastic problems; most of them were failing in one or more subjects. Psychiatric investigation revealed that complicated stories lie behind these failures. In most cases, various pressures—family relationships, social unhappiness, financial difficulty, sex problems—contributed to the creation of an obstacle in the path of scholastic success. In other cases, the students were inadequately prepared for college in the technical educational sense.

It is important to recognize the universality of such problems among all students. It is important to remember that the students we have treated are a cross section of the university. Of the undergraduates seen in the last ten years, 16 per cent were members of senior societies and about 75 per cent belonged to fraternities and participated in all college activities—varsity sports, the *News,* the literary magazine, the glee club, Dwight Hall, and other organizations.

It is, therefore, apparent that most students in the process of growing up face situations that may cause them special difficulty. Our job is to be constantly on the alert to recognize the difficulties as such and to study the individuals in an effort to discover why they have those difficulties and how they may best meet them. Our main purpose and most important need is to find that "why." In order to learn *why* one student fails, *why* another is a drifter, *why* a third antagonizes people and rebels against authority, we go "behind the scene." That is, we set out to discover just what facts, experiences, and attitudes lie behind the ordinary gestures and activity of each individual. Now, a physician can go behind the scene more thoroughly and more easily than most people because he takes a whole history of the individual and doesn't—at least in the beginning—select for emphasis one aspect of the individual's experience. History-taking covers all phases of the individual's life: the physiological—that is, his health, its history and development; the personality—that is, its make-up and tendencies; the sociological—that is, the social and family influences to which he has been subjected and his reactions to them; the various factors in his total development and general preparedness for college and life situations. In other

words, the subject of study is the total person as an individual, and as part of his environment. One instance will illustrate what is meant by such investigation.

> A student was referred to us by his physician because he had been excitable and fearful during a recent illness. When seen, the boy was agitated and complained of having "jitters." This student had always appeared calm, easy-going, and steady. His fellow students regarded him as a good athlete, dependable in a game, and a leader in the group. Their only complaint was that he was lazy because he refused to go out for a major team.
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> This student's laziness was in reality a strong desire not to go out for the team. He disliked the strain of play, for he feared that the tension would bring out his excitability. When he was excitable, he was "jittery," fearful, and—he thought—foolish as well.
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> A study of the boy's history revealed many unsuspected elements in his background. First, in personality he was fundamentally an anxious, fearful individual. These temperamental qualities were aggravated by difficulties in his impulsive life and by the uncertainty of his status in relation to his family. He had been a protected child, and he missed his parents and their customary attention. At the same time, however, he did not want to be too closely involved with the family—he was beginning to desire some freedom. In addition to all this, he had not done so well scholastically as he had anticipated, and this disappointment was deflating. Altogether, this student's problems embraced nearly the whole of his life. Staying away from sports was a necessary protection—for he didn't want to risk revealing all these problems when in a tight spot.

Studying the student does not always mean solving all his problems—there will be times when we may disappoint you in what we accomplish with students you refer. And there will be times when you may disappoint us—in not recognizing when a student needs special study. But in order to achieve any success in this experiment in counseling, we have to work together. And this brings us to the discussion of your main job and ours.

You have, as we have also, some responsibility for the welfare of Yale undergraduates. More particularly, you are responsible for the welfare of freshmen. That welfare can be more specifically defined: as counselors your job is to facilitate the student's adjustment to Yale so that a minimum of time, energy, and attention will be consumed by overcoming unnecessary obstacles. Yale is most interested in its freshmen—as this reorganization of the counseling system testifies. Yale is aware that students in the process of adapting their

personalities and experience to the demands of a new society may encounter emotional strain—and consequently Yale is taking steps to mitigate that strain wherever possible. Our experience will, we hope, be of service to you in approaching the task you are facing.

First, as we have already indicated, it is necessary to recognize that a student in some difficulty that requires psychiatric attention need not appear conspicuously abnormal in his behavior, nor does his problem have to be large and knotty to be disturbing to him. He does not have to be queer to need help.

Second, remember that the freshman entering Yale is a growing boy facing a new environment. Adapting oneself to a new world is always a difficult job and particularly so for boys of college age. For the individual student is at this time in a period of transition; he is approaching maturity on all levels. He is developing physically and undergoing bodily changes which sharpen his reactions to life about him—you might say that physically he is "feeling his oats." Intellectually, too, he is growing. He is open to influence and to new ideas—he is gaining information, developing opinions, attitudes, and prejudices. He is forming values. Now some of these values may follow patterns already set by earlier training at school and in the home; some may conflict with those earlier patterns, and affect another aspect of the individual's development—namely, his relationship to his family. The freshman is physically separated from his family, but emotionally he is usually still closely bound to it. For some this is not a new event; for others it is the first experience of independence, of being placed alone in a society where they have to learn to live without the special assistance and protection of the family. They are breaking the apron strings which, until now, have been more or less the decisive factors in their emotional lives. They have to find a place for themselves in this new environment so that they can feel secure. They have to be able to reconcile conflicting attitudes and values without being shaken and upset because new values may challenge established loyalties—especially loyalty to the family and home.

It is not, then, a static individual, but a dynamic one in process of change who meets Yale for the first time and begins

to adjust to its demands. The first adjustment to be made is the scholastic one. A reasonable measure of scholastic success is the necessary basis for any security that the individual may hope to achieve in the Yale Society. The scholastic standards are high and the resources of the student are exploited by tasks that require ability to handle work independently and intelligently. The next problem is one of social adjustment—and Yale, like any other society, has its special *mores,* customs, and standards which have to be recognized, learned, and more or less conformed to. Most individuals need to conform. And, like most societies, Yale is not especially tolerant of nonconformists, unless they are remarkably talented. The task is not an insuperable one if the student is reasonably at ease in other parts of his life. But if he is subject to many changes and many pressures, he will undoubtedly find his Yale experience hard sledding. The case of one such student illustrates our point.

This student was not doing well in his first year at Yale, he was lonely and friendless, and left at midyear. He entered another college and repeated the same experience. He had few friends, his work was not going well, he did not get on with his instructors—for he felt unjustly treated by them. He did not flunk out of this college, but there was a mutual desire that he leave it. He did and applied to Yale for readmittance, where his case was thoroughly reviewed by this department as well as by the dean's office. Every one was curious to know why this boy who entered Yale with a reasonably good record should fail to make an adjustment here and elsewhere.

A detailed study revealed, first, a difficult and unorganized personality. The boy was moody, sensitive, shy, and touchy. His companions were boys and girls much older than he; he did not go with his contemporaries because he was unable to compete with them. In an older group he did not have to compete. At Yale, this meant that the student could not make friends with his classmates and was very much out of things. Next, this student had been fond of an older girl, and she had dropped him. In general, his scholastic preparation and intelligence were only fair. He had no specific interests so that his talents were not directed or organized, and their effectiveness was lessened. We should say parenthetically that we do not expect freshmen to be fully organized individuals; what they require is the ability to organize themselves in time of need. This boy lacked that capacity and was, therefore, unprepared to carry on well in the face of an acute situation which arose and threatened his whole security. That crisis involved his family. His parents had not been getting along well for some time, and the father finally decided to leave the mother, who was having an affair with another man. You can see that the presence of all these interferences would hinder the student in his effort to make the grade—scholastically and socially—at any college.

We have observed that many boys who flunk out are, in scholastic training and intelligence, as good as or better than many of those who pass their college courses. The causes of failure often have nothing to do with scholastic ability and achievement. Occasionally, it may be an organic defect that is at the bottom of the difficulty. One student who was failing was accused by an instructor of cheating, for, although his answers were correct, the work on his paper was all mixed up. It appeared that this student was word blind and transposed words and phrases as he read and wrote. Another student may be organically sound, but emotionally disturbed by family pressure that he be a Yale man in the family tradition as athlete or scholar. Such pressure is a definite handicap, not only because it sets up arbitrary standards for the student, but also because it may be pushing him into college against his own wish.

One boy, for instance, was forced to come to Yale against his will, and he soon had difficulty. He was seen by the psychiatrist because he was failing in his work, and his father wanted an investigation of the reasons for his failure. It was soon discovered that the patient had long wished to go to West Point. His father, however, wanted him to go to Yale. The father was not a Yale graduate, but he was associated with many Yale men and believed that it was the finest place a boy could go. He was almost fanatic in his desire to have his son graduate from Yale, and when he saw him fail, he believed that he was mentally unbalanced. He would accept no other explanation.

The psychiatrist found that in addition to lack of interest, the boy was handicapped by poor preparation. He would have had to work hard to make up for the deficiencies in his training, and, of course, he did not want to do this. He wanted to go to West Point, not Yale.

It was difficult to convince the father of the boy's handicaps and lack of interest. He resented the fact that the psychiatrist did not find his son a "mental case," but a boy who was where he did not want to be. Subsequently, the patient entered West Point. Four years later, he led a brigade of cadets through the portals onto Yale Field. He was head of his group, happy and successful.

Another student not only wanted a different career, but was totally unprepared for Yale and was pushed in by family pressure.

This boy had poor intellectual ability and lacked interest in college work. Whatever interests he had were directed toward mechanical things and not academic ones. The student came from a wealthy family. The boy's father and brothers were Yale graduates and had done well at college, scholastically and socially. The boy, although he sensed his lack of ability, was troubled by a strong feeling of inferiority in regard to his brothers and father and desired to make good.

This boy's difficulties were twofold. He was faced with an almost

insurmountable lack of ability; he was admitted to Yale with a very low scholastic-aptitude score. He had been to several schools and done poorly in all. In addition to this, he was under pressure from his family, who supervised him strictly and were determined that he go through Yale. The patient was antagonistic to his father and full of resentment. The antagonism between the boy and his family was fostered by a psychologist under whose care the boy had been for some years. This man tried to give the boy a rationalization for his scholastic failure and this in turn made him want to fight his family. The psychologist tried to make him believe that if he once opposed his father and won, he would be forever free.

The psychiatrist attempted to find a neutral ground on which to work. He began treating the patient and had him supervised by a special tutor at the same time. He soon saw, however, that college was not the place for the boy. His continued failure and emotional stress were driving him into a deep depression with suicidal ideas. The psychiatrist, therefore, informed the parents of the boy's condition and advised them to withdraw him from Yale. He also recommended that since the boy had mechanical interests and some ability, he be encouraged to do mechanical work. The boy was withdrawn from college in the middle of his first year.

Social, family, and sex adjustment are the main sources of problems other than scholastic difficulties. Problems involving family relationships and sexual development are usually discovered through indications in the student's social or scholastic behavior.

We have already said that a complicated emotional life does not always manifest itself in unusual behavior. So that puts you on the spot. By now you are perhaps asking yourselves what type of case you should send to us for study and what kind you can work with alone. I should say that you should work with those boys whose problems you *know* you know. Even then you'll make mistakes—but every one does. You will tend to send us the obviously "queer" boy, and he may not need us as much as others do. He may be just queer—he may be a bright boy getting along in his own way and adjusted in that way. In fact, you may seem queer to him. No, it is the rather ordinary boy who may really need help, and there are ways of determining if he does.

Within certain limits, health is one indication of emotional well-being. Many physical complaints, such as migraine, gastrointestinal disturbances, high blood pressure, and insomnia, arise from emotional distress. If a student shows frequent fatigue, has many colds, needs excuses for over-

sleeping and cutting of classes, he should be investigated. Watch the way your boys act with the group; you can tell if a boy in your entry mixes well or is outside the gang—alone and without companions. Keep your eye on the boy who "beefs" a lot. But don't worry about every boy who is seclusive or moody, so long as he is productive and doesn't complain. After all, we're not trying to mold every one to the same pattern. If you find a student with a good scholastic record, a good aptitude score and predicted average, not fulfilling his predictions, study him. He may beef about things, and his complaints about not being able to make friends or about the way the college is run may have some basis in fact, but not quite enough. You should remember that reformers may be trying to work out their own problems. When you find that these boys need further study, the next step must be carefully taken. A visit to the psychiatrist is still a difficult admission for many people, and the effect of popular prejudice frequently makes it hard for students to be persuaded to consult us. But a reluctance of this sort can be overcome by careful tact. A boy can be told that he really ought to talk his difficulties out with some one experienced in such things and that he should just go over to the health department where there's a man who has helped students in similar circumstances. The boy should ordinarily be willing to do so. But he will not—I can assure you—if he is told, as was one student I know: "There's something wrong with you. Why don't you go over and get psychoanalyzed?" You wouldn't either.

This, briefly, is the job before you. I hope you understand that we shall be available to you not only to take over students, but to discuss with you any aspect of your work in which we may be of help. You will have our full coöperation. I should, however, make clear one point—when we see a student, the information he gives us is strictly confidential. We can give you only general recommendations about him and no details of his history without his express permission. You will, I am sure, understand the necessity of our maintaining such professional confidences. I am also sure that you will realize that this does not lessen our effectiveness in being of service to you.

EFFECT OF FOSTER-HOME PLACEMENT ON THE INTELLIGENCE RATINGS OF CHILDREN OF FEEBLEMINDED PARENTS

REPORT OF A STUDY CONDUCTED BY THE CHILD-CARING AGENCIES OF SAINT PAUL, MINNESOTA *

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FOR several years, the Amherst H. Wilder Child Guidance Clinic of Saint Paul has been increasingly aware of the problems presented by the families of the children referred to it for study. Interest has spread, from the specific problem for the study of which one child was referred, to the total situation, including the problems of the other children in the same home. It has become more and more evident, as we have gathered information in regard to the family as a whole, that children whom the parents report as presenting no problems often show every evidence of maladjustment and every prospect of getting into trouble in the near future. The parents in such cases are often too dull to recognize in their other children the first stages of the very problem for which the patient has been referred for help. As we have watched one child after another of the same family get into difficulty as soon as he reached an age where something more than the most elementary physical care was required, we have come to question the advisability of leaving any children with feebleminded parents. Perhaps protecting children already born from a feebleminded environment may be as necessary, from the standpoint of community welfare, as preventing the birth of more children with a feebleminded heredity.

* The data from which the tables in this article were compiled are on file in the library of the University of Minnesota.

In April, 1937, the director of the clinic, Dr. H. S. Lippman, called a meeting of the child-caring agencies of Saint Paul to discuss the problem. It was found that the workers of these other agencies were equally interested. Through Dr. George Stevenson, of The National Committee for Mental Hygiene, a grant was obtained from the George Davis Bivin Foundation of Cleveland, making possible the employment of a full-time worker for four months to collect and organize the data furnished by the coöperating agencies.[1] Later, the aid was extended to six months, in order to bring the study to a logical stopping point.

From the beginning, the study was regarded as exploratory. It was hoped that vague questions would take definite form in the light of specific data, and that the study would result in a series of well-defined problems that would serve as a starting point for further research, not only for our group, but for other child-caring agencies. There were numerous questions to which some sort of answer would be desirable from either a practical or a theoretical standpoint. The first step, therefore, was one of elimination, in order to formulate a problem so simple that a tentative answer might be found during a brief period of investigation.

It was decided to limit the study to a comparison of two groups, each consisting of 100 children with one or both parents feebleminded, the children of one group having been allowed to remain in their own homes, while those of the other had been placed in foster homes. Throughout this report, the first group will be referred to as the "own-child" group, and the second as the "foster-child" group.

[1] The coöperating agencies were: the Bureau of Catholic Charities, represented by Florence Osborne; the Children's Home Society, represented by Florence Johnson; Children's Service, represented by Gladys Wolcott; the County Welfare Board, represented by Ruth Bowman, Case Supervisor, Florence Harris, of the Child Welfare Department, and Gertrude Johnson, of the Aid to Dependent Children; the Jewish Welfare Association, represented by Clara Diamond; the State Board of Control, represented by Dr. F. Kuhlman, of the Bureau of Research, Lucille Quinlan, of the Children's Bureau, and Mildred Thompson, of the Feebleminded Department; and The Amherst H. Wilder Child Guidance Clinic, represented by Dr. H. S. Lippman, Dr. Grace Arthur, Ruth Atchley, and Louise Smith. Mrs. Smith was especially helpful in the writing of the original report from which the present summary is taken.

In the selection of cases, the first requirement, of course, was that one or both natural parents be feebleminded. In Minnesota an individual who has difficulty in adjusting to the requirements of society may be committed to the state board of control as feebleminded if his Binet intelligence quotient, obtained by the State Bureau of Research, is 75 or below. That intelligence quotient is used, therefore, to define the upper limit of feeblemindedness in this study.

Each child used as a subject had had at least two Binet examinations. The own-child group had been tested, and retested after an intervening period of at least two years, in their own homes. This interval was regarded as the minimum in which any measurable changes in rate of intellectual growth would be likely to occur.

The foster-child group had been tested during residence with the natural parents or within two months after removal from them, and retested after a sojourn of at least two years in a foster home. It is now clear that a further limiting requirement should have been that the first test had been given within a specified time before the foster-home placement. The median interval for the group used was 5.17 months, with a quartile deviation of 4.14 months. Where children were tested in infancy and then allowed to remain with the natural parents for four or five years before foster placement occurred, it is impossible to determine whether changes took place before or after placement. There are few cases of this kind, however.

Cases were discarded if there had been a diagnosis of grand mal, psychosis, or syphilis of the central nervous system for either parent or for the child. No child was included who had been returned to his own home after a period of foster-home placement, even though later he had been returned to the foster home and had spent the required time there. Neither were children included who had spent more than six months in a receiving institution between the removal from their own homes and foster-home placement. From the own-child group cases were discarded if the child had been out of the home for more than three months of any one year. The idea was to eliminate the "in-and-out" group,

which was suspected of presenting specific problems of its own serious enough to demand separate study.

As it was difficult to find 100 children for each group who satisfied the above requirements, no cases were rejected upon any other basis than those listed. In the own-child group, 45 families were represented; in the foster-child group, 61 families. Nine families were represented in both groups.

None of the foster-child group had been placed for the purpose of adoption. Some had been removed from one foster home to another during the interval between test and retest. All the foster homes were licensed by the state, and supervised by some one of the child-placing agencies coöperating in the study.

In only five cases had foster-home placement been the direct result of the child's own behavior. The reasons given for the removal of the other 95 cases from the own homes included institutionalization of one or both parents, delinquency of parents, death of one or both parents, desertion, drunkenness, and neglect. Where these reasons were given, all the children of the family had been committed. This does not mean that all were included in the present study, however, as some failed to meet the requirements outlined above.

Intelligence ratings were supplied by the State Research Bureau, the Saint Paul Public Schools, and the child-guidance clinic. All had been obtained with the Kuhlmann, the Kuhlmann-Binet, or the Stanford-Binet scales, except one retest which had been obtained with the Kuhlmann-Anderson given as an individual test. In time a large enough number of cases may be available to make it possible to group them according to the tests used.

The average chronological age of the own-child group at the time of the first test was six years and seven months; that of the foster-child group was five years and six months. The average I.Q. of the own-child group on the first test was 81.06; that of the foster-child group, 79.69. From this it appears that the two groups were surprisingly well matched in this regard, considering that the selection of the two groups was made without any attempt to secure uniformity by artificial control. Whatever advantage exists appears in favor of the own-child group.

At the time of reëxamination, the own-child group had an average chronological age of twelve years, while the foster-child group averaged ten years and five months. The average I.Q. of the own-child group had dropped 6.68 points below the average obtained upon the first examination. The average I.Q. of the foster-child group had increased 1.43 points. These figures for the two groups are as follows, the minus sign indicating a drop in rating, the plus sign a rise:

	Own-child group			*Foster-child group*		
	Test	Retest	Difference	Test	Retest	Difference
Mean I.Q.	81.06	74.38	—6.68	79.69	81.12	+1.43
Standard deviation of I.Q.'s.	15.39	12.89		14.40	14.61	

Heinis has shown that for large numbers of cases, the I.Q. tends to vary in a definitely predictable fashion.[1] He has given us a formula for predicting change in I.Q. for any level and over any period of time. Tables [2] have been constructed from this formula which enable a layman to apply Heinis' findings to ratings obtained with any revision of the Binet scale. Because the rating obtained with this formula tends not to change with the passing of time, Heinis calls it a "personal constant." Changing our I.Q. values into terms of this personal constant, we get the following:

	Own-child group			*Foster-child group*		
	Test	Retest	Difference	Test	Retest	Difference
Mean personal constant.	87.58	87.37	—.21	85.28	90.18	+4.90
Standard deviation of personal constants.	11.67	8.41		11.70	8.69	

That is, the own-child group at the time of the first test had an average personal constant of 87.58. On the retest, the average personal constant was 87.37. The difference, —.21, is too small to have significance. The own-child group as a whole had continued at the same rate of mental growth during

[1] See "A Personal Constant," by H. Heinis. *Journal of Educational Psychology*, Vol. 17, pp. 163–86, March, 1926.

[2] Table of Heinis Personal Constant Values. Minneapolis: Educational Test Bureau, 1933.

the interval between tests as had been established at the time of the first test.

The foster-child group, at the time of the first test, had an average personal constant of 85.28. At the time of the retest, the average personal constant was 90.18. The gain of 4.90 units is large enough to indicate a definite change in prediction for the group as a whole.

The Minnesota State Research Bureau classifies intelligence ratings as follows:

Feebleminded	I.Q. under 75
Border line	I.Q. 75–84
Dull	I.Q. 85–94
Average	I.Q. 95–104
Bright	I.Q. 105–114
Very bright	I.Q. 115–124

Classifying our data upon this basis, we get the following:

	Own-child group			*Foster-child group*		
I.Q.	No. of cases	Median point change in I.Q.	Quartile deviation	No. of cases	Median point change in I.Q.	Quartile deviation
Under 75	30	0	5.25	35	+11.00	10.63
75–84	30	—4.34	8.00	33	+3.50	7.94
85–94	23	—11.50	6.25	18	—7.00	10.50
95 or over	17	—16.67	6.63	14	—14.34	8.00
	100			100		

In terms of I.Q., the feebleminded level is the only one at which the own-child group does not show loss. The foster-child group gains more at the lower I.Q. levels. The dull and average groups show loss.

In terms of personal constant, the results were as follows:

	Own-child group			*Foster-child group*		
I.Q.	No. of cases	Median point change in personal constant	Quartile deviation	No. of cases	Median point change in personal constant	Quartile deviation
Under 75	30	+4.61	4.89	35	+12.19	7.93
75–84	30	+1.00	5.60	33	+5.68	4.09
85–94	23	—3.50	3.97	18	—1.60	5.47
95 or over	17	—9.93	4.13	14	—6.00	4.38
	100			100		

Here the own-child group shows a gain at the feebleminded level, a non-significant gain at the border-line level, and a loss in average rating for the higher classifications. The foster-child group shows gain at the feebleminded and border-line levels, but begins to lose at the dull level.

Thus we find that retest ratings tend to approach the average rating of the group on the first test. Those testing lowest on the first examination tend to show the greatest increase on the retest. Those testing highest on the first examination tend to show the greatest loss on the retest. This tendency stands out even more clearly when expressed in terms of personal constant than in terms of I.Q. In both it is clear that, at each intelligence level, the average foster child has fared better than the average child of the own-child group.

To every one concerned with child placing, the age of placement has seemed to be of major importance. To judge from our findings, this impression appears to have a solid factual basis. The median-point change in intelligence rating and in personal constant for those of the own-child group who were first tested before five years of age and those who were first tested after five were as follows:

	Tested before five	*Tested after five*
Number of cases	28	72
I.Q.:		
Median point change	—8.00	—6.00
Quartile	11.00	5.97
Personal constant:		
Median point change	0.00	—.84
Quartile	8.50	3.75

The corresponding changes for those of the foster-child group who were placed before five and those who were placed after were as follows:

	Placed before five	*Placed after five*
Number of cases	38	62
I.Q.:		
Median point change	+8.16	—4.50
Quartile	8.34	9.44
Personal constant:		
Median point change	+11.00	+.90
Quartile	8.63	4.24

For 38 children of the foster-child group who were placed in foster homes before they reached a chronological age of

five years, there was a median gain in I.Q. of 8.16 points. In terms of personal constant, the gain was 11.00 points. For the 62 who were placed in foster homes when they were five years of age or older, there was a median loss in I.Q. of 4.50 points. In units of personal constant there was a median change of less than one point (+.90). This would indicate that the children included in the present study who had been placed in foster homes before they were five years of age made, on the average, a large enough gain to change the prediction as to their level of intelligence when they reach adulthood. Those placed in foster homes after they reached a chronological age of five years showed, on the average, neither a significant gain nor a loss, but tended to continue to develop at the rate established before placement.

The own-child group shows no such difference between those given the first test before the age of five, and those tested the first time when they were five years old or older. The personal constant varies only slightly even for the latter group.

It was questioned whether the time elapsing between the first test and the retest might affect results. The values in terms of I.Q. and personal constant were as follows:

	Own-child group			*Foster-child group*		
Interval in months between tests	Number of cases	Median I.Q. point change	Median personal-constant point change	Number of cases	Median I.Q. point change	Median personal-constant point change
24–35.....	17	+1.0	+2.0	17	+5.0	+5.0
36–47.....	17	—5.0	—2.0	25	+3.0	+3.0
48–59.....	16	—5.5	0	17	—3.0	+1.0
60–71.....	14	—10.0	0	19	+1.0	+5.0
72–83.....	13	—12.0	—3.0	9	—8.0	—3.0
84–95.....	8	—8.5	—1.5	3	—13.0	—1.0
96–107.....	6	—14.0	—7.0	5	—14.0	—2.0
108 or over.....	9	—16.0	—2.0	5	—10.0	+2.0
	100			100		

While the I.Q. tends to show increasing loss in both groups with increase of interval between tests, the personal constant is affected but little in the foster-child group. In the own-

child group, however, with an interval of six years or more between test and retest, even the personal constant shows a definite tendency to drop.

For the cases included in this study, it seems clear that from the standpoint of intelligence, as measured by the Binet scale, the average child of feebleminded parents placed in a foster home had a definite advantage over the average child of feebleminded parents who was left to grow up under the care of those feebleminded parents.

The following questions present themselves for further investigation:

1. Fifty cases in the own-child group, upon reëxamination, showed a loss in personal constant. Why did forty gain and ten show no change?

2. Sixty-two cases in the foster-child group, upon reëxamination, showed a gain in personal constant. Why did thirty-three lose and five show no change?

3. Is the "feebleminded heredity" of earlier studies biological or social or both? Is the poor intellectual development of children of feebleminded parents determined by genes; by nutrition, stimulation, habit training, and motivation; or by a combination of all these factors?

4. Why do the children of feebleminded parents earning normal or better than normal Binet ratings on the first examination tend to lose upon reëxamination, whether left in their own homes or placed in foster homes? Further retesting of the normal children included in this study is indicated to rule out chance variation. Additional cases of normal children with feebleminded parents are needed for observation over long enough periods of time to determine school adjustment and general adjustment when they reach adulthood.

5. To what extent is the development of the own-child group affected when there is one normal parent or some other normal adult relative in the home? On the other hand, how is the development of the foster-child group affected by frequent contacts with feebleminded parents?

6. If children removed from feebleminded parents at an early age gain more, on the average, than those removed later, what would be the result if they were removed at birth?

BOOK REVIEWS

EMOTION AND THE EDUCATIVE PROCESS. By Daniel A. Prescott. Washington: American Council on Education, 1938. 323 p.

Unless all signs fail, this book of Dr. Prescott's is likely to be one of the really important educational books of our day. Written as a committee report to a representative national organization that most people would consider at least reasonably conservative, it strikes vigorously at current notions of the purely intellectual function of education, and in a most timely way draws attention to the possibilities of schools and other educational enterprises as having to do with the emotional aspects of life as well as the intellectual.

From the start the book raises significant questions about emotion—or, as Dr. Prescott prefers to say, "the affective processes." It seeks to find out "whether emotion has been unduly ignored in the stress laid upon the acquisition of knowledge and the development of skills"; "whether education should concern itself with the strength and direction of desires developed or inhibited by the educational process"; "whether the stress laid on the attitude of neutral attachment, desirable in the scientific observer, has been unduly extended into other spheres of life to the impoverishment of the life of American youth"; and—in the event that it should appear desirable for education to concern itself more directly with the development and direction of emotion—"to consider by what devices emotion may be more accurately described, measured, and oriented."

Although Dr. Prescott's committee undertook a careful and detailed examination of the literature for the purpose of ascertaining what knowledge about affective experience and behavior might safely be assumed to be valid fact, no claim is made that a full resumé has been given of the experimental findings of affective psychology. Sufficient material is included, however, not only to show the trend of psychological theory, but to indicate significant weaknesses in educational psychology as this subject is ordinarily presented to prospective teachers. Without attempting to decide what stand ought to be taken on the various issues involved in the concept of "emotional maturity," Dr. Prescott's committee asserts that, with the present limitations of scientific knowledge, "philosophy must continue to play a large part in determining the objectives of education with regard to the training of affective behavior." Most school

practices will remain a compromise, the author says, but he points out that, if we do continue to beg this question, we shall resign ourselves to a most non-functional type of education.

With respect to the problem of educational methodology, "exponents of complete freedom write as though it were seriously limiting a child's personality development to direct or choose the experiences that he is to have," while others imply that unpleasant disciplinary measures to enforce safe or reasonable behavior are deterimental to "sound" character, and some hold that children never should undergo experience of failure, of frustration, or of deprivation in anything they earnestly wish to do.

Dr. Prescott pays some attention to controversies between persons who are essentially "moralistic" and those who might be called "psychiatric." He points out that under some conditions "protective or fantastic lying, truancy, daydreaming and social withdrawal, failure to conform to the rules of the school, stealing, and sexual play may be regarded as wilful and malicious wickedness or as the inevitable results of situations which the child cannot meet successfully." Dr. Prescott's committee also points out that, while schools are now rendering important service both to the emotional adjustment of children and to the enrichment of their affective experiences, a long period of research and experimentation must be completed before any one will be able to speak with confidence regarding the proper rôle of affective experiences in education. Furthermore, the committee says, we must do all we can at once to increase our knowledge of the psychology of the affective life and to apply our limited knowledge through educational agencies. "Emotions and emotionalized attitudes may be used as effectively for regimentation and demagoguery as for the development of worthy social motives or the furtherance of democratic procedures of social adjustment." Accordingly, says Dr. Prescott, "it is essential that a well-thought-out social philosophy underlie all attempts at educational experimentation involving strong sentiments."

The report lists certain aspects of education that need study from the point of view of emotion—understanding the affective characters of children, the educativeness of school curricula, the motivation of school tasks and curricular experiences. It describes some of the personnel problems in education, and closes with a series of conclusions in which the needs are stressed for more detailed and valid information about the physiology and psychology that underlie individual differences, the influence of different intensities of emotion upon the higher mental processes, and the rôle of feeling and emotion in æsthetic experience and in artistic production. The report cites

a number of conditions and practices that will have to be investigated by experts in mental hygiene to discover whether the profession of education has within itself certain special hazards to mental health. There is a good deal of evidence, Dr. Prescott believes, that the profession makes serious demands on the poise and adjustment of the persons who engage in it:

> "Because the personal relations experienced by children in schools loom so large in educative influence and value, school boards and administrators must be held accountable for the mental and emotional wholesomeness of the persons whom they place in contact with children. But teachers are also people—the impossible cannot be expected or demanded of them; and, if research shows that they are frustrated and burdened emotionally beyond what a normal person can stand, then social action in their behalf must be forthcoming from parent-teacher associations, women's clubs, churches, service clubs, and all other agencies for community betterment. Not until penetrating studies of the conditions that teachers face have been made and published can this effective social action be secured."

W. Carson Ryan.

Carnegie Foundation for the Advancement of Teaching, New York City.

Rediscovering the Adolescent; A Study of Personality Development in Adolescent Boys. By Hedley S. Dimock. New York: Association Press, 1937. 288 p.

Not since G. Stanley Hall's *Adolescence* has there been so important a book on the nature and character of the adolescent boy as this by Dean Dimock. Here is a book that should be required reading for secondary-school people, scout leaders, Y. M. C. A. secretaries, and certainly for parents! And the delight of it all is that although it is a report of a well-conceived and carefully conducted research, it is decidedly readable.

The reviewer, in the course of a fairly well-occupied life, lets himself in for this book-review business with certain reservations and usually with a reluctance to get started on what may be a painful task. When *Rediscovering the Adolescent* came to his desk, he again upbraided himself for his weakness in having said "Yes" to a plea for a book review. But first off came Hugh S. Hartshorne's challenging and inviting preface, which promised enough, but not too much. Believe it or not, the preface was enough to send the reviewer plunging into a task that became a fascinating voyage of rediscovery indeed.

Well-documented, full of well-constructed tables and charts, and with the clever pictograms of Harold Haydon, the volume is a striking

illustration of the fact that research into human behavior can be acceptably reported. What a joy it is to have the charts, tables, and pictograms right where one wants them, without having to turn pages and lose one's place and patience at the same time! What a pleasure it is to have correlation procedures adequately reported and not over-interpreted! Just as the reviewer was about to cry "over-interpretation," time and again the author would "beat him to it" by a well-placed caution against jumping to conclusions. An almost unique example of this occurs on page 85, where Dean Dimock, after presenting some striking contributory evidence which nine out of ten authors would have boldly claimed as infallible proof, makes the comment, "We would hazard the conjecture that this feeling of superiority in the physically inferior boys is a compensatory attitude produced by the basic thrust for a sense of status, adequacy, and worthfulness."

Time and again current views concerning the sex development of the pubescent and post-pubescent boy are challenged. Again and again we are jolted out of the complacency of preconceived notions about boys of the 'teen age, and forced to question our own attitudes or our own smug educational programs. We have indeed traveled far since G. Stanley Hall.

The study of 200 boys continuously for four years, if well done, as was the case in this survey, can scarcely help yielding important new evidence. As Dr. Hartshorne says in his preface, "so carefully conducted is this study of relationships that educators are duty bound either to make corresponding changes in procedure or to conduct such researches as will overthrow its conclusions."

Why do adolescent boys leave Sunday School? Why do they tend to become spectators rather than participants in active play? Why is it that, contrary to our current belief, they exhibit no adolescent spurt of creative energy or idealism? Is it possible that we in education are not "on to our jobs"? How do boys make friendships? What of unrequited friendships and the gaining or losing of status? How much of the development of personality and behavior depends, not upon the phenomenon of physical growth or pubescence, but rather upon socio-economic background, normality of size, and family expectation? What of weaning from the family control? Are adult patterns of behavior a matter of maturation or of imposition? These and many other urgent questions are opened up, subjected to appropriate study, carefully and painstakingly checked, and then reposted in an unprejudiced manner. The book is as interesting as a good detective story, and yet there has not in a generation been as sound a piece of research in the particular area attacked.

This reviewer believes that a review that completely paraphrases a volume and waters it down for the easy digestion of lazy readers is the wrong kind of review. Read the book! Keep it on your desk and reread it! Take this (p. 274) as a starter: "Somewhat in harmony with this possibility is the interpretation that the adolescent is in a no-man's land between his lost status as a child and his unattained status as an adult."

The book is so good that it should be a best-seller. Thank fortune that there is still some one who is willing to be an iconoclast without being a sensationalist!

M. E. Townsend.

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Play and Mental Health. By John Eisele Davis. New York: A. S. Barnes and Company, 1938. 202 p.

Several investigators have made extensive surveys and studies of the play activities and recreational life of children and young people. To organize and relate these data in accordance with children's *needs* is a stupendous undertaking, but it is a service that is greatly needed. Case studies, made by pioneers in the field of mental hygiene, have demonstrated that the play life of the child may be directed in such a way as to relieve emotional tensions and improve mental health; and systematic recreational interviewing is now recognized as an essential phase of individual diagnosis in many psychological clinics. But a guide for teachers to use is still lacking.

In *Play and Mental Hygiene,* John Eisele Davis has attempted to relate and organize the scattered and isolated material, to develop "a psychology of play in line with the spirit and the recent advances of psychiatric practices in child education," and to illustrate sound procedures that may be followed by modern teachers.

Play is considered as "modifiable experience which in the hands of the child and the hygienically trained teacher possesses so many elements out of which to organize and project lessons vitally related to the child's most effective growth and wholesome development. Among the many contributions of play, there are two most significant fundamentals of wholesome personality adjustment: (*a*) the delicate element of interest so necessary to valid educational effort; (*b*) a sense of individual worth-whileness and personal security evoked through the rational development of motor skills."

The social value of play is emphasized in Chapter I. To create the successful social being rather than the successful individual is an important goal of education to which the play life of the child may contribute significantly. The teacher, as a student of the genetic growth of children, should attempt to understand children's motives.

And in no aspect of life other than play has she the opportunity to observe the child's motives and purposes so freely released and consummated. The modern teacher, therefore, is giving increased vitality to her work by studying the play of children; and by selecting and fostering those patterns which are in harmony with worthy individual needs and purposes, she is promoting sturdy growth.

Study of the play life of the child will disclose numerous and frequently incompatible motives. To reconcile these in a balanced, integrated play and recreational life is a task that requires continuous study and deep appreciation. One of the most subtle and difficult tasks that confront the teacher is to alleviate the growing child's conflicts through guidance of his play life.

Compensatory mechanisms find many expressions in play. The desire to attain ego status is frequently thwarted in the school, with the result that make-believe play and compensations in the form of identification or projection are frequently resorted to as methods of escape. "The unsuccessful player may attempt to compensate also by identifying himself with another individual who is especially skillful or with a team, the united action of which will hide his defect and the success of which will increase his prestige. He refers positively to the successful players as 'we.' These identifications are, of course, important modes of adjustment and may also lead to desirable behavior, as when the individual identifies himself with some worth-while social cause." For not all forms of compensatory play are undesirable. Some of them offer a symbolism that enriches thought, and others engender a "saving sense of humor."

> "One of the best ways to meet and correct an oversevere emphasis upon the necessity of winning, which may lead to a disintegrating fear of losing, is to meet the situation through some humorously relaxing approach. The teacher above all should have a hardy sense of humor; with this attribute he will be able to present play as a bright and happy rather than a serious and overly responsible activity."

The author discusses certain "types" of children and shows how undesirable patterns of play may be redirected by sympathetic guiddance. Thus, the timid child may find a natural and wholesome awakening of aggressive qualities through play activities which are selected in accord with his physical capacity, his mental ability, and his interests. One of the most beneficial results of such activities is the dissipation of unwholesome fears. Although the author emphasizes the therapeutic value of play and recreation in abnormal cases, his orientation is essentially sound, for he holds that the first responsibility of education is to promote the normal growth and happy development of the child. However, "every teacher of physical education should have opportunity to observe abnormal

types in play, for from such study many most valuable and interesting clues may be obtained as to its effect upon personality."

One excellent emphasis is found in the author's discussion of the way in which an abundant play life may provide *referents* for the growing vocabulary of the child. The 600 words acquired by the child between the ages of two and three are associated in varying degrees of clearness with food, clothing, names of people and places, and many other items. There exists in play life an avenue that may be utilized to give richness and clarity to the growing vocabulary. Thus, as the child acquires 600 new words each year during the period between two and six years, he may be so guided in his play that he will find opportunity to use and acquire a vocabulary that is individually appropriate in terms of his particular developmental needs. Far too often does the school narrow or curtail the vocabulary development of the child, who, upon entering the first grade, is required to learn basic lists of *new* words which have little or no meaning in terms of his past experience or present needs. The anxieties and fears that often attend these restrictions may be alleviated by the free and spontaneous expression that a rich play life affords. Thus, play, properly conceived, will have therapeutic value. Its worth, however, extends beyond this, for rich and varied experiences followed in a spirit of play may offer the opportunity for continuing the development of a vocabulary that serves basic needs. *Referents* for new words so acquired will improve communication and enhance language development generally.

The volume has several distinct weaknesses. One of the most conspicuous is the ease with which the author appears to accept certain general tendencies as characteristics of particular age levels. For example: "The six-year-old enjoys dramatic play and is interested in games involving individual competition; complicated group game and gang activities are not evident as yet." "The twelve-year-old has reached the typical gang age; his interests are characterized by restless activity. He takes part readily in team games and develops an interest in checkers, cards, and so on." Had more representative and comprehensive studies of play activities been consulted, this oversimplified emphasis would have been avoided.

In a discussion of the rôle of play in a cultured life, the author makes up for the inadequacy of the foregoing treatment. His position is carefully developed and illustrated:

> "One of the difficulties in the way of a cultural appreciation of play is the mistaken idea that education is a superior primary function and that recreation is a secondary, inferior, and less purposeful process. When play awakens the creative side of the child, it produces the highest

> order of education and advances to art, in the words of Jacks, 'when it is raised to its highest excellence, its highest beauty and highest power.' ''

It seemed to the reviewer that the most successful and convincing sections of the book are those in which play is viewed as a *process* which can be directed to promote sturdy growth. The following qualities of ideal play are examples of this commendable emphasis:

> ''There are five important qualities in promoting a more ideal play: first, the experience should be thoroughly honest; second, the particular play activity should be adapted to developmental age and interest; third, participants should be given the satisfaction which comes from equal chances of winning. From the mental-hygiene standpoint one-sided games are harmful. Fourth, play should be presented as a coöperative social experience rather than a physical struggle for individual dominance; fifth, the objectives set forth should emphasize the group winning ideal and the lasting satisfaction which accrues to the lone individual when winning with the group.''

These considerations are very important, since the student who approaches the problem of the relationship of play to mental hygiene may be led to overemphasize the importance of case-work which employs play activities to alleviate personal conflicts, emotional frustrations, and abnormal behavior patterns. These conflicts should always be viewed in terms of the social fabric which has had so large a part in producing them. A healthy mind and a hygienic life are attained usually in a society that respects individuality and permits the expression of basic life needs. No amount of case-work, however skillfully planned, will replace active efforts to alter certain social conditions which produce individual and group maladjustments.

Merely to alter the individual so as to enable him to conform or adjust to the demands of a society in which wholesome growth is continuously and progressively thwarted or limited is a rather futile enterprise—one that, it seems to the reviewer, too frequently characterizes the work of the psychiatrist. The hygienist who wishes to perform significant and enduring work will prize a society in which normal development is the rule. That basic changes are needed at the present time is revealed in the dicussions of play in two books recently published—*Youth Tell Their Story* [1] and *Rediscovering the Adolescent*.[2] In both of these volumes, one finds descriptions of typical forms of recreation which are questionable correlates in a program of hygienic development. In the latter volume, Dr. Dimock describes the play life of 200 boys during a period which carries the majority of the boys from the pre-pubescent through the post-

[1] By H. M. Bell. Washington: American Council on Education, 1938.
[2] By Hedley S. Dimock. New York: Association Press, 1937.

pubescent stage. It was found that the number of play activities participated in decreases with increase in age. Thus, as the boy becomes older, he narrows his range of activities, he spends larger blocks of his time in fewer activities. In this connection, the following finding is significant: The "big four" activities in the passive-spectator category include listening to the radio, going to the movies, riding in an auto, and "watching athletic sports." These and other passive or amusement types overshadow—indeed, replace—active and creative pursuits.

Thus, fragment by fragment, the presentation takes a total form which leads to one inescapable conclusion: Our contemporary society is overburdened with obstacles to wholesome personality orientation and growth. Our social fabric contains numerous agencies and institutions, which, in their present forms, are far removed from the personal and social needs of adolescents to-day. These agencies are shown to affect and standardize the life and thought of the home, the school, and the community. The task of social reconstruction and individual rehabilitation, therefore, depends upon a concerted effort to foster sturdy growth from childhood to adequate adulthood through the creation of new and more appropriate designs for living.

Play and Mental Health, properly oriented in this social framework, should prove a valuable contribution to the education of teachers. In fact, the reviewer knows of no other treatment of play that is so relevant to the needs of teachers to-day in helping children attain more adequate and happy adjustment.

PAUL WITTY.

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MODERN WAYS WITH BABIES. By Elizabeth B. Hurlock. Philadelphia: J. B. Lippincott and Company, 1937. 347 p.

This book is designed to serve as a practical compendium on the care and rearing of infants during the first three years of life for parents without scientific training. Its purpose, as stated by the author, is "not to present a new philosophy of education, but to bridge the gap between the scientific investigator and the parent." "It is my hope," Dr. Hurlock adds, "that this scientific material, combined with knowledge which parents themselves will gain from practical experience with their babies, will result in a better understanding of how to deal with the everyday problems that arise during the babyhood years."

The book follows the conventional pattern of organization and is well and clearly written. It is replete with practical suggestions on the handling of everyday matters that arise in the course of the baby's daily routine, and these suggestions are made in such a simple, direct

style that no woman of ordinary intelligence could fail to understand what the author recommends.

All this sounds very fine. And yet, in my opinion, it is this very plethora of suggestions and their very exact and concrete character that constitute the book's greatest drawback. It is true that there are careless parents who need frequent warning of the possible ill effects of neglecting the little and seemingly trivial matters connected with child care. But these parents rarely bother to read books on the subject. For the inexperienced, but conscientious mother who tries to carry out faithfully all the instructions laid down for her, I am inclined to think that the book may easily prove to be a source of anxiety rather than help. The frequently reiterated warning that "children will not discard undesirable habits of their own accord," with its accompanying italicized "rule"—"Never allow an exception to occur until the habit is overcome"—must obviously be taken *cum grano* if the mother is not to develop a rigidity of thought and action that is likely to lead to more serious consequences than those she is attempting to avoid. The author has apparently little faith in the efficacy of normal growth in suitable surroundings for the eradication of infantile behavior patterns that, if continued, would be classed as undesirable. Always she feels that something active should be done about them.

Another source of possible anxiety to the mother of little experience is to be found in the standards given as criteria of the normal development of various functions. In many cases these standards are beyond those attained by the average baby of the ages specified. Few babies use one word "with understanding" at the age of ten months, or from three to seven words at the age of one year, though the average child can repeat a few words, parrot fashion, at this time. The statement (p. 71) that "the ability to reach an object is so well developed by the age of five months that the baby rarely misses the mark," is a decided overestimate according to the findings of Shirley and of Gesell and Thompson. In these and other instances, more recognition of the principle of normal variation and fewer pronouncements of a definite "should be able" nature might be less disturbing to the young mother, who is all too frequently overanxious lest her child should not be developing normally. It would also have been desirable to make more of a distinction between those features of child training that may properly be regarded as essential and those that are of less basic importance.

Some of the attempts to develop rules for child training on the basis of research intended for quite a different purpose lead to rather ludicrous results. For example, the first hundred words from Thorn-

dike's famous word list, which was compiled on the basis of the frequency of word usage in the written discourse of older children and adults, are quoted as "the first words which a baby should learn." Elsewhere it is pointed out that a baby's vocabulary in the beginning is made up chiefly of nouns, but this recommended list includes only six nouns, of which the word *man* is the only one likely to appear early in the child's vocabulary. Instead, he is to be taught such concepts as *time, year, against, before, after, many, more, much, way,* and five different forms of the verb *be*. All this before his third birthday!

In spite of its many excellent features, I am of the opinion that the book is one that can hardly be recommended indiscriminately to mothers of little training or experience. Perhaps the explanation lies in the author's initial statement that she made no attempt to present a philosophy of education. For after all even the training of babies, if it is to be sound, must have its roots in a firm soil of social and educational theory. It cannot be encompassed by a mere set of formal rules.

FLORENCE L. GOODENOUGH.

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CHILD PSYCHOLOGY. By Fowler D. Brooks, with the collaboration of Laurance F. Shaffer. Boston: Houghton Mifflin Company, 1937. 600 p.

This volume may be regarded as a companion to the author's *Psychology of Adolescence*. It presents a very straightforward and comprehensive survey of the psychology of human development during the first twelve years of life, draws upon an extensive experimental literature, and organizes the material on a common-sense and eclectic basis. As a means of introducing the reader to this very important field of study, the book is excellent, interesting, and challenging, clearly marking out countless paths for further study and research.

The scope of the work is indicated to a degree by the following selections from the topics discussed: the mechanisms of heredity; prenatal and postnatal development of structure and function; the nature and significance of the behavior of infants; the mechanisms of learning; the development of physical and motor capacities, language, and mental functions generally; problems of emotional and social behavior; and the mental hygiene of personality growth. Particularly in the latter half of the book there is a very able emphasis upon the practical applications of child psychology, and a realistic treatment of the problems confronting the parent and educator, because of the nature of the child, on the one hand, and the major social influences, on the other. Controversial discussion has been reduced to a minimum, but without dogmatism.

Apart from descriptive comments of the type given above, there is little to be said. There is no one particular point of view to carry the material as a thesis, for the author's aim has been to present factual evidence and acceptable observations concerning the many facets of child development. If any bias is shown, it is only that of the objective scientist; although the author departs even from that bias when he wishes to include an observation concerning human growth that the systematically pure objectivist would omit. The student reader will find much material, however, on which to exercise his own philosophy of development; and in the process that philosophy will undoubtedly be enriched.

W. LINE.

The Canadian National Committee for Mental Hygiene.

THE BACKWARD CHILD. By Cyril Burt. New York: D. Appleton-Century Company, 1937. 694 p.

The name of Cyril Burt is quite familiar to Americans whose interests include clinical psychology, social hygiene, education, and related subjects. Since in the past his attention has been centered largely upon the problem of human misfits, it is not surprising that he should now devote an entire book to the subject of the backward child. Under the term "backward," he includes only those groups of mentally retarded children who might reasonably be considered as educable or trainable, not the hopeless cases of pronounced mental deficiency.

In his Preface, he states that the book is addressed primarily to teachers, and this is obviously true, but the material covered in the text is so comprehensive that any one interested in this broad field should find plenty to occupy his attention. After several chapters designed to orient one in such matters as the incidence of backwardness and the detection, classification, and investigation of it, the main topic of the book is introduced—namely, the causes and treatment of educational backwardness. These etiological defects are grouped under seven general headings as follows:

The *social* causes of backwardness include, among others, unfavorable factors within the family circle, in the neighborhood, in the community. Under *scholastic* causes are discussed such classroom problems as laziness and dishonesty. Two chapters on *physical* defects take up both developmental and general disturbances. The latter are especially well handled, with the listing of numerous contributory physical defects. The chapter on *sensory* defects emphasizes particularly visual and auditory problems, both of which are

admirably handled. Left-handedness and speech defects are the two main *motor* troubles discussed. The chapter on left-handedness may in another era seem needlessly long and involved (90 pages), but under existing controversial conditions it could not safely be reduced. The chapter on speech defects, also long, is well done, but it makes the problem appear almost too simple so far as treatment is concerned. The section that deals with *intellectual* factors in backwardness is divided into general and special causes. Under general causes, heredity is named as the chief offender, but other mental disorders are not overlooked. The special intellectual factors that cause backwardness include disturbances of perception, association, attention, imagery, habit formation, and others. *Defects of temperament and character* are found in cases of instability, neurotic make-up, moral defects, apathy, and so on.

The final chapter, entitled *Summary and Practical Conclusions,* is devoted largely to a coördination and discussion of the various treatment methods recommended throughout the book. Since from 60 to 70 per cent of the cases seem to be "inherently and irremediably handicapped," success may be expected in a relatively small proportion. This being the case, emphasis in treatment is placed upon those who might respond most favorably.

The book closes with an appendix of some fifty pages dealing with case-record forms, growth curves, statistical criteria, and hints on speech training.

This is the second volume in Professor Burt's series on the subnormal school child, the first being *The Young Delinquent.* It may be used to advantage both as a text and as a reference work. At several points undue attention to unimportant details needlessly lengthens an already sizable volume, but minor defects of this sort do not really mar a book in other respects so well written. Frankly, a review of reasonable proportions can hardly do justice to a work of such eclectic content.

EUGENE W. MARTZ.

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TEXTBOOK OF MENTAL DEFICIENCY (AMENTIA). By W. F. Tredgold, M.D. Sixth edition. Baltimore: William Wood and Company, 1937. 556 p.

This sixth edition of Dr. Tredgold's book continues the excellent exposition of mental deficiency for which its predecessors have been noted, giving the advances that have been made in the field since the last edition was issued. To quote from the preface: "In order to bring this edition up to date, the chapters on Etiology, Psychology, Pathology, Secondary Amentia, and Sociology have been extensively rewritten; considerable additions have been made to the chapters on

the Nature of Mental Defect, Clinical Examination, Mental Tests, Diagnosis and Legal Procedure; a section has been added on the Chronological Development of the Normal Mind; and the whole has been subject to revision."

The practitioner or student who wishes a complete summary of the subject of mental deficiency would do well to read this book. It gives clearly and concisely the essentials of what is known of this affliction, which is so prevalent. Too often, in general practice, the physician is questioned by an anxious parent in regard to the etiology, prognosis, treatment, and so on, of mental deficiency in a child, and is unable to give accurate information concerning the condition. For him, this book is especially recommended. For more detailed information, the specialist in mental deficiency would have to refer to technical monographs written by various investigators who have dealt with specific phases of mental deficiency.

This reviewer would suggest that a chapter on the history of mental deficiency would have been quite apropos. Dr. Tredgold brings in historical data from time to time in the subject matter, but in keeping with the general clarity of his book, it seems that a separate chapter, on the early work with and progress in knowledge of mental deficiency, would have been in order.

The chapter entitled *Treatment and Training* left this reviewer a bit disappointed. From the practical standpoint, training mental defectives to be self-supporting, if possible, is one of the most important therapeutic procedures. Of course, in a volume such as this, the writer cannot go into too great detail, but it seems to me that because the rehabilitation of defectives is such an important phase of mental-deficiency work, Dr. Tredgold might have elaborated on it a bit more than he did.

Also, he does not go into the matter of treating cases of cerebral palsy by means of muscle training and relaxation, a type of work that promises to be a valuable aid in treating these actually or apparently defective children.

Another method of treating defectives so that they may become less of a burden on society is not mentioned by Dr. Tredgold, and that is the family-care program, as carried out in New York State. In this important group of cases, the patients are taken from an unsatisfactory environment and placed in one that is better suited to their abilities.

These minor criticisms, however, should not detract from the volume. It is a well-written discussion of a subject that at best is most difficult to understand, and any one interested in the mental defective will benefit by reading it.

JACOB SIRKIN.

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THE MECHANICAL ABILITY OF SUBNORMAL BOYS. By Miriam C. Pritchard. (Contributions to Education, No. 699.) New York: Teachers College, Columbia University, 1937. 73 p.

This modest little volume presents the results of a carefully planned and competently executed study of an important aspect of the guidance and training program for subnormal boys. The findings, which are of large practical significance, may be summarized under two major headings.

First, many boys of subnormal intelligence equal or surpass boys of normal intelligence in mechanical ability. More specifically, 79 Jewish boys averaging 14.9 years in chronological age, 10.9 years in mental age, and 74.6 in I.Q. were compared with 100 Minnesota boys averaging 12.4 years in chronological age, 12.5 years in mental age, and 101.1 in I.Q. in respect to scores on the Minnesota paper form-board series, the Minnesota spatial-relations boards, and the Minnesota assembly boxes. On the first two of these tests, both of which measure intelligence in part and both of which attempt to eliminate the factor of familiarity or experience, the normal boys were superior by differences which were ten and four times as large as their respective probable errors. On the third test, which does not correlate with intelligence and which measures experience in part, the subnormal boys were superior by a difference which was nearly twenty times as large as its probable error. That is, normal boys have more original or innate mechanical ability, but subnormal boys are far superior in practical ability to manipulate more or less familiar mechanical objects. On this last test, this reviewer estimates from Pritchard's data that not one of the normal boys did as well as the average subnormal boy, and that 95 per cent of the subnormal boys exceeded the average of the normal. This is an extraordinarily large difference, but two supporting studies are cited, one of which credits subnormal boys with an even greater advantage in practical mechanical ability. Although these findings happen to be an incidental by-product of the study, the author is curiously blind to their significance and less than two pages are devoted to their presentation.

Second, radical changes in psychological-testing programs for subnormal boys need to be made, less emphasis being placed on I.Q.'s and mental ages and more on specific vocational and trade tests. This conclusion follows from a study of such variables as ratings of mechanical ability by manual-training teachers, actual shop performance, I.Q.'s, mental ages, and the three tests in the Minnesota mechanical-abilities battery. The measurement of these factors and a study of their interrelations constitute the major portion of the

study. It is clear that neither mental age nor I.Q. are more than slightly related to mechanical ability as measured by ratings, shop performance, or scores on the Minnesota tests. It is equally clear that mechanical abilities as measured by ratings, shop performance, and the Minnesota tests are closely interrelated. Age, height, weight, and personality and social adjustment factors are very slightly related to the available measures of mechanical ability.

These findings, on the one hand, emphasize the importance of a broader testing program and, on the other, suggest the possibility of much more effective guidance. The author recommends less emphasis on abstract intelligence in selecting children for special classes, the provision of special shop training for those with distinct mechanical ability, and a differentiated curriculum for the subnormal who lack ability and interest in mechanical pursuits.

FRANK K. SHUTTLEWORTH.

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NEW LIGHT ON DELINQUENCY AND ITS TREATMENT. By William Healy, M.D., and Augusta F. Bronner. New Haven: Yale University Press, 1936. 226 p.

In this study, Drs. Healy and Bronner have pointed up their years of experience in a concentrated effort to understand 153 delinquents and their families and especially 145 controls paired against the delinquents. Part of the work was done by the authors themselves in Boston; the rest came under their direction through assistance in New Haven and Detroit.

The authors feel that this critically planned attack, free from some of the pressures of a service job, has given them a new perspective on delinquency. It has, in addition, clarified certain earlier perspectives: "First, it becomes evident from our data that there is practical value in a more penetrating interpretation of delinquency as a form of rational behavior just as dependent on definite causations as is any other form of behavior . . . that delinquent behavior has meaningfulness for the individual constitutes, then, a second orientation. . . . This brings us to our third orientation—a formulated outlook on treatment possibilities."

Their studies have enabled the authors to prognosticate more definitely on the basis of social and psychopathological liabilities. In Group I, they place those cases in which the psychopathological liabilities are great, and they find scant returns on their treatment efforts in this group. In Group II, they place cases in which the social pathology is high; this group appeared on treatment to be more modifiable. The best results were obtained with the cases in Group III, in which neither the psychopathological nor the social

liabilities were great, although the children were seriously delinquent.

These groupings represent one of the important contributions of the work from a practical standpoint, since they offer those working with delinquents an immediate lead as to where effort may be directed most effectively. If Group I is regarded as a challenge to be met by repeated attacks, the use of this classification will be a distinct scientific gain; if, however, it is used as an excuse for escaping from responsibility for treatment, it will retard progress.

In general, the authors see delinquency as a multi-determined thing. It is often difficult to sort out those correlates that are fundamental from those that are incidental. They believe, however, that an important fundamental is the thwarting of normal urges in the individual, which thwarting induces him to seek some alternate to social behavior as a means of gaining satisfaction. The presentation of an antisocial pattern by the environment offers the individual a positive antisocial solution of his conflict. "Comparison of the emotional experiences and emotional reactions of delinquents and controls shows by far the greatest difference that we have been able to discover between the two groups." The percentage of cases with emotional disorders was, according to their estimates, 91 for the delinquents as compared with only 13 in the control group. The emotional problems included feelings of rejection, deprivation, insecurity and misunderstanding, feelings of being thwarted, feelings of inadequacy or inferiority, discomfort about family disharmony, jealousy, internal mental conflict, and guilt.

The life situation of the delinquent, from which he derives his antisocial ideation, involves his family chiefly. The evidence of these studies is that "family life in case of delinquency has not proved to be the bulwark of defense against growth of antisocial behavior which, in the formulated ideal of our civilization, it is supposed to be." Among the 153 delinquents, the family situation was good in only 22 instances, and in only one of these families was there more than one delinquent; whereas in the case of the rest of the group the incidence of other delinquents in the family was nine times as great.

Of course, many other factors correlated with the findings of the authors, but the extent to which these are primary is not clear. Interference with normal, healthy development was much more prevalent among the delinquents and they showed hyperactivity, everrestlessness, extreme physical aggressiveness, and great impulsiveness, whereas these were not at all characteristic of the controls.

This study is important in giving to those who are struggling with delinquents some really valid first steps in procedure and in throwing doubt upon some of the customary handling of delinquents by courts,

indicating why certain of these efforts have had results the contrary of those desired. GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

SOCIAL PSYCHOLOGY. By Ellis Freeman. New York: Henry Holt and Company, 1936. 491 p.

The author has undertaken here "the task of presenting a psychological basis for understanding some of the most characteristic aspects of our society and of the changes which it is undergoing." He has succeeded remarkably well in this difficult task, and deserves credit for deviating from the usual organization of material in texts on social psychology. Professor Freeman has his intellectual and social biases and rides them hard, but always openly, so one cannot complain too much on this count. He gives evidence of understanding unusually well the society in which he lives, and, at the same time, scolds this society—or at least those who, he believes, rule it—for having failed to make the correct social and rational choice of values. As is indicated in his Introduction, the concept of conflict of values is utilized as the coördinating principle for an understanding of our culture and, especially, of the economic relationships characteristic of modern American society.

There is so much thoughtful material in this book that any review must of necessity be selective and inadequate in its estimate of the entire volume. To proceed to the task, psychologists, sociologists, and economists will be interested particularly in the chapters that deal with the creation and perpetuation of values, values of special groups, impartiality, acquisitiveness, and associations. Professor Freeman has set himself the considerable task of integrating the technical literature of several fields, such as cultural anthropology, sociology, sections of economic theory, and phases of history, in addition to the materials of the several divisions of psychology. He has done well in his attempt, but there are serious gaps in his orientation; at least this is true within those fields with which the reviewer is familiar. One can do no less than indicate these in the course of commenting on certain portions of the book.

An early chapter of the work gives a good analysis and refutation of the group-mind concept. This impresses the reviewer as the flaying of a cadaver, for the concept has long since been abandoned by sociologists and social psychologists. German, American, and English sociologists never placed great emphasis on it, and Durkheim in France was the only important supporter of this tool of group analysis. The reviewer strongly questions the author's statement (p. 28) that "the fallacy of the group-mind . . . partially owes its

perpetuation to a deliberate intent to foster a nationalism for the benefit of a dominant class." We also wish to take sharp exception to the author's explanation of the social barriers existing in the Southern part of the United States with regard to sanctioned sexual relations between whites and Negroes. He believes that this barrier rests upon the effort of the white ruling class to retain the Negro in his present subordinate economic position (pp. 89, 102). In the opinion of the reviewer, the sexual, cultural, and historical aspects of this question are far more important than the strictly economic ones. John Dollard, in his *Caste and Class in a Southern Town,* has offered a far more cogent explanation of Southern *mores* in this connection.

The author has made considerable use of materials on primitive societies (p. 165), but has unfortunately limited his materials to certain selections from the works of Levy-Bruhl, Malinowski, Briffault, and Boas. His assertions as to the lack of individuality in primitive society are open to serious question if a wider field of literature is utilized. Reference to the *Festschrift* volume presented to Peter W. Schmidt in 1928 will afford valuable corrections of the Levy-Bruhl point of view. Likewise, his statement that primitive societies do not reveal stratifications of a social, economic, and educational nature is simply not true, as even an elementary examination of the literature on various primitive groups will reveal. Robert Lowie's *Primitive Society* will serve as an antidote on this issue.

In the main, we are inclined to approve of Professor Freeman's treatment of values, and believe that students of the social sciences will find his equilibrium concept of values provocative and valuable. A point on which one would differ with him is in connection with his assertion (p. 147): "These culturally conditioned values assume the *immutable form of facts of nature* [italics mine] because within the group the individual practices them habitually and remains unaware of alternatives." The reviewer would like to discover any values of our culture which have not been challenged by some group or other since the turn of the twentieth century. The existence of a book such as this one is evidence that present-day culture is highly self-critical and that value-configurations are at least open to analysis and discussion. The dynamic nature of the present social order, so strongly emphasized by Professor Freeman, would render relativity of values unavoidable, especially in view of the increased rates of social interaction within the United States.

Whether or not there are laws of associations, as set forth by the author, remains an open question, but his discussion of the formation of associations, especially certain modern ones, is profitable and to the point.

While disagreement with Freeman's analysis of the rôle of acquisitiveness in society is possible on some points, on the whole it is excellent, as the following excerpt (p. 317) will indicate: "Living in an acquisitive society, we assimilate from infancy, through formal and informal instruction, the idea that wealth is the sole, or at least the most effective, means of getting security, recognition, and a full realization of the self."

One final point deserves mention—the author recognizes full well (p. 319) that economic activities are merely social forms in which *primary and prior drives and motives are expressed.* It follows that society needs (if society needs anything) a recanalization of motives and drives so as to change the content of those political and economic forms which frustrate and baffle so many of us to-day, as well as alteration of socio-economic institutions. This task calls for both social and individual reorientation, not merely for the development of a particular set of economic institutions. The processes of time are gradually working to this end. An interpretation of history and society in terms of economic institutions suffices as an explanation at a given *level* of analysis. It is not, however, the final answer to the search for knowledge of the essential nature of man and society.

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SOME AMERICAN PIONEERS IN SOCIAL WELFARE: SELECT DOCUMENTS WITH EDITORIAL NOTES. By Edith Abbott. Chicago: University of Chicago Press, 1937. 189 p.

Here is another useful volume emanating from the University of Chicago's School of Social Service Administration. A preprint of a documentary history of social welfare to be published later, it brings together several important documents previously reprinted in scattered numbers of the *Social Service Review,* together with informative editorial notes by Miss Abbott.

The compilation includes excerpts from the writings of seven social-welfare pioneers, four of whom, interestingly enough, made outstanding contributions to the progress of the care and treatment of the mentally ill. Benjamin Rush (1745–1813), the first pioneer included in Miss Abbott's book, is known as "the father of American psychiatry." A man of remarkable versatility, he was actively interested in most of the humanitarian movements of his time. Two excerpts from Rush's writings are included; the first is taken from his eyewitness description of the yellow-fever plague which decimated Philadelphia in 1793, the second from his touching biographical sketch of a fellow philanthropist, Christopher Ludwick.

Benjamin Franklin (1706–1790) is represented by an extract from

his account, published in 1754, of the origin and early years of the Pennsylvania Hospital. Franklin was mainly responsible for the founding of this, the first general hospital and the first institution to provide curative treatment for the mentally sick in this country. An active leader in the eighteenth-century reform movement in Philadelphia, his important rôle in the development of American social welfare has been obscured by his more spectacular exploits in the fields of statesmanship and science.

Miss Abbott next presents Thomas Eddy (1758–1827), a New York Quaker who displayed the same broad interest in humanitarian enterprises as his Philadelphia contemporaries, Franklin and Rush. Active in the anti-slavery and prison-reform movements and in various organizations for ameliorating the condition of the poor, Eddy was a typical representative of the burgeoning middle-class reformers of his day. He was largely instrumental in founding the Bloomingdale Asylum (now the Westchester Division of the New York Hospital), one of the earliest mental hospitals in this country to adopt the humane system of "moral treatment." Miss Abbott has chosen for her collection Eddy's *Hints for Introducing an Improved Mode of Treating the Insane,* a paper read in 1815 before the governors of the New York Hospital. The recommendations made in this paper, based on Tuke's system of "moral treatment," were approved by the governors and led to the establishment of Bloomingdale soon afterward.

Of the seven pioneers discussed in this volume, Stephen Girard (1750–1830) most closely approaches the present popular conception of the "philanthropist" as a generous financier of charitable enterprises. Perhaps the wealthiest American of his time, Girard bequeathed most of his $7,000,000 fortune toward a "college for poor white orphans." The original endowment has grown to approximately $73,000,000. Part of Girard's remarkable will, with its well-known safeguards against the inculcation of religious prejudices in the orphan beneficiaries, is reprinted in the volume under review, and it makes absorbing reading.

Samuel Gridley Howe (1801–1876), pioneer in the care and treatment of the physically and mentally handicapped and in public-welfare administration, is represented by an extract from his account of the education of Laura Bridgman, his famous deaf-blind pupil. This selection is followed by his *Principles of Public Charity,* an important contribution to the theory of public welfare in this country, which appeared originally as part of the second annual report of the Massachusetts Board of State Charities, of which Howe was chairman. Howe took an active part in the establishment of the

Massachusetts Board, the first centralized state public-welfare body in America.

Dorothea Lynde Dix (1802–1887), the great crusader in the cause of humane treatment for the mentally ill, is appropriately represented here by excerpts from her memorial to Congress in 1848 praying for a huge grant of federal lands toward the erection and maintenance of state hospitals throughout the country. This appeal, later concretized in the "12,500,000-Acre Bill" drawn up by Miss Dix, was voted on favorably by Congress in 1854, only to meet defeat by the veto of President Pierce. Had her bill become law, it would have established the principle of federal aid in public welfare, a principle that finally gained official sanction only within the past few years.

Charles Loring Brace (1826–1890), founder of the Children's Aid Society, is the seventh social-welfare pioneer represented in this volume. The first circular issued by the society in 1853 is included, together with an extract from Brace's entertaining book, *The Dangerous Classes of New York,* describing how the society placed out its first group of children in the West in 1854.

Appendices in the volume include four significant public-welfare documents published in the period 1870–1885.

One might be inclined to question the editor's choice of the pioneers and documents included in this book as not entirely the most representative or the most significant were it not for her disarming prefatory explanation that the major criterion for selection was the availability of certain material for classroom use. As it is, we can only express appreciation for the grouping of this scattered source material into a convenient volume, while looking forward to the larger work promised.

ALBERT DEUTSCH.

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DIFFERENTIAL PSYCHOLOGY; INDIVIDUAL AND GROUP DIFFERENCES IN BEHAVIOR. By Anne Anastasi. New York: The Macmillan Company, 1937. 615 p.

This book presents the findings of differential psychology—or the study of individual differences—tracing its beginnings to earliest times and leading up to the more recent developments in the study of individual differences through the newer statistical tools of factorial analysis.

The author points out the relative rôle of heredity and of environment in causing these differences. She stresses the influences of growth and maturation on individual differences, discusses the rela-

tionship between physical and mental traits, and carefully examines the literature on types, pointing out the negative nature of present-day evidence regarding the existence of types.

The second part of the book take up the differences in some of the major groups into which human beings are divided; among these are included sex and racial differences, and differences in such groups as the abnormal, the subnormal, and the highly gifted. Emphasis is placed upon the relative importance of cultural versus biological factors, and a short closing paragraph stresses the value of multiple-group affiliation for personality development.

For the student of mental hygiene, this book offers a compact and readable compendium of the major findings of the school of differential psychology. It is perhaps timely to ask whether this school has not overstressed the importance of individual differences to the utter neglect of the importance of individual similarities. Actually, we are usually more interested in knowing what group an individual is most like, rather than how much he differs from others. This obverse problem, if treated with the same exhaustiveness as that with which the differential psychologists have treated their problem, ought to bring gratifying results.

JOSEPH ZUBIN.

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THE PROFESSIONAL THIEF. By A Professional Thief. Chicago: The University of Chicago Press, 1937. 270 p.

Under the direction of Professor E. H. Sutherland—who has been at great pains to check its accuracy through other sources—this account was dictated some years ago by Chic Conwell—a reformed thief who died in 1933. The language is rather startlingly that of the thieves' own vernacular—"startlingly" because except for this the reader feels himself for the most part viewing a profession quite as organized, established, and orderly as any other.

This is not an autobiography; even the many bits of illustrative material are carefully clipped so that any concept of an actual person constantly eludes the reader. Rather is it an attempt at the depiction of a professional by a member of it who uses bits of experience to illuminate his points. It is a discussion of thievery—not of the professional thief.

The structure of the profession, its mode of protecting itself from the Law, its outlook as a promising career, consume six chapters. Two others attempt to give some picture of the social and family life of the professional thief and of his real attitudes toward his victim—society.

Perhaps the part most likely to excite professional workers

is Professor Sutherland's clear demonstration that professional thievery has all the accepted credentials of a profession: 1. The professional thief has a complex of abilities and skills. Specialization within the field is apparently decreasing (medical men take note—it *can* be done). 2. The professional thief, within the world that touches him, has professional standing. No social worker's nose was ever turned higher over the untrained worker than the nose of the professional thief over the sneak thief—and such. 3. The profession of theft is a complex of common and shared feelings, sentiments, and overt acts. Any group of thieves can work through a racket with the same efficient mutual understanding and protection of one another's interests shown by a group of lawyers in milking a receivership. 4. Differential association is characteristic of professional thieves—the group defines its own membership. This laying on of hands is as necessary and as determinative an act as in our shepherding group. 5. Professional theft is organzied, in the sense that it is a system in which informal unity and reciprocity may be found. Without a national association, a pension fund, or "tenure," it nevertheless provides these services in an informal way in its solidarity, its care of members in trouble, and its rather rigorously followed apprenticeship procedure.

There's something awfully disturbing about this whole business. When you get to know the maladjusted child well, he turns out to be very normal. When you really know the delinquent, he turns out to be a very ordinary, average fellow. And now thievery appears to be alarmingly like our most respected and important professions.

Professor Sutherland has done a service in demonstrating the similarities existing between thievery and other professions. Can the sociologist show the differences, the quirks, the it-went-wrong-here side of these pictures, or must this remain the field of the psychiatrist?

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Newark, New Jersey.

DIE FAMILIENPFLEGE KRANKSINNIGER (FAMILY CARE OF THE MENTALLY ILL). By Ernst Bufe, M.D. Halle: Carl Marhold Verlagsbuchhandlung, 1939. 230 p.

Family care of mental patients is winning favor throughout the civilized world. Its possibilities and its advantages are gradually being recognized, and active interest in family-care methods is being developed. The question is no longer, Is family care practicable? but rather, What system of family care should be adopted? and, To what extent should family care be used? The book before us is designed to assist in answering the latter questions.

The author of this valuable volume is Dr. Ernst Bufe, Director of Allenberg Mental Hospital, at Wehlau, East Prussia, and one of the most enthusiastic advocates of family care in Europe. Before going to Wehlau he was on the medical staff of the mental hospital at Uchtspringe in the Saxon province of Prussia. It was here that Konrad Alt did his great work in the development of family care, and it was here that he wrote his small treatise, *Concerning the Family Care of Mental Patients.* The mantle of Konrad Alt fell on Ernst Bufe, and the latter, for several years past, has been a leader in promoting family care in Germany.

In *Familienpflege Kranksinniger,* Dr. Bufe sets forth the history of the development of family care in the various countries of Europe. The period prior to 1902, which was covered in Alt's book, is briefly summarized. The period since 1902 is given more thorough treatment, and the status of family care in all of the principal countries of the world is described.

The second part of the book deals with the value of family care and the methods used in various countries in selecting patients and families and in supervising the work. The author realizes that methods must vary and, to be effective, must be adapted to local conditions. It is noteworthy that nearly every intelligent effort to establish family care has met with success.

A valuable feature of the book is the discussion of the advantages of family care. These are set forth under three headings—namely (1) advantages for the hospital, (2) advantages for the family that cares for patients, and (3) advantages for the patients.

Under the first, the author quotes Kolb, who says that family care is the best means of instilling new life into the routine of an old mental hospital, and of showing the personnel and the community the possibility and the desirability of extramural treatment. In every mental hospital are many old cases that would respond favorably to the better living conditions found in good homes. Relieved of such patients, the hospital would have a better opportunity to give intensive treatment to new admissions. The work of the hospital is aided by family care, as the latter in many cases expedites improvement and recovery and prepares the way for parole and community care. Moreover, with an adequate system of family care, a mental hospital is insured against overcrowding.

Under the second heading the author mentions several advantages that accrue to the family that cares for patients. The most obvious of these is the steady income obtained, and the gain derived from the labor of patients. Other advantages are the outlet for altruistic sentiments and the raising of the standard of living in the home in response to official requirements for family care and frequent inspec-

tions. Homes in which patients are cared for become better furnished and better kept, partly because they are open for official visits at all times and partly because the family wishes to measure up to its responsibilities.

Under the third heading the author sets forth the principal advantages of family care to patients, as follows:

1. An approach to normal existence.
2. A larger measure of freedom than is possible in a hospital.
3. Recognition of individual needs and wishes.
4. An opportunity to be of service to others.
5. An opportunity to enjoy community life.

These advantages and others are thoroughly discussed.

Die Familienpflege Kranksinniger supplements in excellent manner the book of Konrad Alt published in 1903. It should exert wide influence in promoting family care in German-speaking countries.

HORATIO M. POLLOCK.

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INTRODUCTION TO CLINICAL PSYCHOLOGY FOR STUDENTS OF MEDICINE, PSYCHOLOGY, AND NURSING. By Edward M. Westburgh. Philadelphia: P. Blakiston's Son and Company, 1937. 336 p.

The author defines clinical psychology "as a body of organized knowledge and as a systematic technique of adjusting individuals to themselves and their environment." Because only "a few men and women have learned through personal experience how to correct personality deviations and how to help keep children and adults in good mental and nervous health," and because "students of psychology and medicine have no access to this accumulating knowledge of facts, principles, and methods," this book has been written. The author adds: "If Clinical Psychology is to be established as a profession, a systematic presentation must be made of sound psychological techniques that shall be effective in correcting maladjustments, in changing specific emotional and behavior patterns, in improving the total personality picture."

With this evidence of loose thinking and actual misstatement from the Preface, the reader is thoroughly warned as to the "scientific" monstrosity first gaining the light of day in the chapters to follow.

With a fine disregard of the body of psychiatric experience as a practical working psychology based on the experiences of many workers, the author sees psychiatry being saved from the sterility of structuralism only through psychoanalysis and the data of clinical psychology. He appears to be unaware of the fact that those items he claims for his profession have been the common property of all

psychiatrists for at least two generations—all those men who, working with people and to help people, have accepted as a truism that such people are alive and that the study of them must be alive, dynamic.

That psychology should pay a belated tribute to psychiatry by seeking to imitate it should perhaps be cause for some gratification at the awakening. Such rejoicing will be tempered seriously and give way in the end to grave doubts when a further perusal of the book leads to two conclusions:

1. The Clinical Psychologist (author's capitals) has absorbed little of what is to be learned, to judge from the careless use of terms and concepts, as:

> "Endocrinology may be the key to the cure of 'moral imbecility.'"
>
> "The idea of the relationship between superiority and strength of sex drive remains a most useful clinical speculation."
>
> "The unsuccessful, the poor, the unsatisfied can find compensation in the belief that they will have in full what they now lack when they pass through the 'Pearly Gates.' . . . Compensation by belief in future life can make individuals ineffective and useless as workers in the cause of human betterment in this world."
>
> "We note that some people escape from hardships and unhappiness by becoming very much depressed emotionally. . . . Others do not have to face their feelings of guilt because they are physically so slowed down that they cannot talk except very slowly, move extremely slowly, and coördinate poorly and, in extreme cases, they are almost incapable of any motor response. These slowed-down patients are said to show psychomotor retardation; the extreme condition is called 'catatonia.'"
>
> "On the opposite side of the picture, we have people avoiding the unhappy and the difficult problems of life by expressing an over-amount of happiness, or euphoria."
>
> "The easiest way to get information [*re* sex] from a boy is not to ask if he masturbates, but to ask how often he masturbates and when he started. Ninety-nine out of a hundred will say they did masturbate and how often, but that they have stopped."

These few illustrations will suffice to show the old shopworn stock-in-trade of those who never get beyond the jargon of "facing it," "escape," "compensation," "conversion," "sex drive," and so on, and the reliance on "techniques." Where is there any evidence that people are studied for what they do, irrespective of the irresponsible interpretative jargon of the various isms?

But the meagerness of the absorption of the considerable psychological knowledge already at hand, and the poor grasp of the real problems involved, are best exemplified by the author's introduction to a chapter headed, *Health History and Physical Factors:*

> "Performances, emotions, habits, and goals cannot be properly interpreted without reference to health problems. Many a psychologist has

> been misled in diagnosis because of lack of attention to bodily conditions. It is advisable for the non-medical psychologist to be familiar with symptoms of a physical and physiological nature which do, or may, affect conduct. If the need for a physical examination is indicated, he can then get the physician's report. A more ideal situation is one in which the psychologist and physician work coöperatively as a matter of routine."

What follows indicates how utterly dangerous such an arrangement would be if treatment is to be left to the clinical psychologist. The chapter is a tribute to the outmoded mind-body dualism, which, however, because of its vagueness and solemnity, would arouse only scorn from the past masters of dualism.

2. The strong need apparent throughout the book to establish a professional status for the clinical psychologist will meet with encouragement only in settings where loose thinking is allowed in regard to the fundamental concepts of human behavior. The contention of the author that "the clinical psychologist deals with all the problems of human behavior except those existing solely in terms of the diagnosis and treatment of organic diseases, toxemias and drug addictions, and those mental conditions arising solely from organic injuries and neural lesions," will not be granted by those whose feeling of responsibility to patients as living people can see only harm in such artificial distinctions.

The author's training qualifications for the competent clinical psychologist—from one to two years of internship under the guidance of a qualified clinical psychologist and in association with psychiatrists—will do nothing to lessen the alarm of serious workers for the welfare of patients whose "health or ill health, happiness or misery, success or failure depend on the wise or unwise guidance provided by the clinical psychologist."

If the clinical psychologist really desires to achieve professional status, let him serve an apprenticeship in human biology in its broadest interpretation.

The best part of the book is that which treats of the psychologist's most worth-while contribution—to the field of testing. The rest is a congeries of Freudism and borrowings from psychiatry put together in such a manner as to be wholly unacceptable to earnest workers. It will be a sad day for natural history when man is reduced finally to "mechanisms" and "techniques."

WENDELL MUNCIE.

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NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

DR. GEORGE S. STEVENSON APPOINTED MEDICAL DIRECTOR OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

The Board of Directors of The National Committee for Mental Hygiene announce the appointment of Dr. George S. Stevenson as medical director, succeeding Dr. Clarence M. Hincks, who has asked that he be relieved of his duties here, except as part-time field consultant, in order to give more time to the work of the National Committee for Mental Hygiene of Canada, of which he is the general director and founder. Mr. H. Edmund Bullis, who has served as executive officer of our National Committee and as assistant to Dr. Hincks, continues on the staff as part-time business manager.

Dr. Hincks assumed the directorship of the National Committee in 1931, as successor to the late Dr. Frankwood E. Williams, coming to New York on temporary leave from the National Committee for Mental Hygiene of Canada. In deference to our National Committee's needs and the board's wishes, he continued in the position on a part-time basis longer than he had originally intended and at great sacrifice to the Canadian Committee.

We are fortunate in securing the services of Dr. Stevenson as full-time medical director, because of his splendid qualifications, his wide experience in mental hygiene, and his familiarity with the National Committee's work as Director of its Division on Community Clinics during the past twelve years. Expressing his keen pleasure and satisfaction at Dr. Stevenson's appointment, Dr. Hincks paid this tribute to his successor: "I am satisfied that no better man could be found to fill the important post of Medical Director of The National Committee for Mental Hygiene. In his capacity as Director of the Division on Community Clinics, Dr. Stevenson has won my highest admiration and esteem. He possesses the rare combination of a thorough scientific grounding, a broad social outlook, a critical yet tolerant mind, an ability to deal constructively with complex situations, and tireless energy. His great contribution in our field is appreciated by scores of medical, health, and social-work leaders throughout America."

Blackstone Studios

DR. GEORGE S. STEVENSON

Medical Director, The National Committee for Mental Hygiene

An Appreciation

Returning the compliment, and speaking for Dr. Stevenson and The National Committee for Mental Hygiene, we take this opportunity to express our deep appreciation of Dr. Hincks's splendid service and leadership during the past eight years, in many respects the most difficult period in its history. Dr. Hincks took the reins when the great depression threatened the very existence of the organization. In spite of it and against great odds, he not only conserved the organization—tiding it over a hazardous period and enabling it to continue its basic activities—but added considerably to its program of work, initiating a number of new and fundamental activities, and, ably assisted by Mr. Bullis, tapping new and substantial sources of financial support. More than a million dollars was raised and expended for the general and special activities of the National Committee under his régime, which saw the rise and development of new and powerful forces for the advancement and growth of mental-health work.

Dr. Hincks broke new ground in several fields: in the improvemental of mental-hospital services, in research, in mental hygiene in relation to the schools, in professional and public education, and in other spheres of mental-health endeavor. Typical of the fundamental character of many of the activities inaugurated in his time was the five-year program for the strengthening and extension of psychiatric teaching in the medical schools, with results that are changing the whole picture of medical education in this respect. Where formerly only a handful of medical schools could boast of adequate psychiatric departments, fully half of them can now be said to be giving psychiatric instruction of a reasonably high standard. A notable collateral development, influenced by the psychiatric-education program, was the establishment of the American Board of Psychiatry and Neurology, an exceedingly important adjunct in the elevation and maintenance of standards in psychiatric and scientific training in this country.

Scientific research in psychiatry and mental hygiene has been noticeably quickened and stimulated through the impetus furnished by the research program in dementia praecox instituted four years ago, under grants from the Scottish Rite Masons, Northern Jurisdiction, U.S.A., and by the canvassing and appraisal and encouragement of scientific interest and activity in the mental hospitals of the country. This work has influenced, directly or indirectly, increased appropriations of public and private funds for psychiatric investigation and is leading to better planning in research and to the discovery and training of research talent in this field.

In the field of hospital services there has been a new accession of

organized effort to conserve the gains of former years and push to higher levels of promise and performance the care and treatment of the mentally ill. A new organization of forces, involving the collaboration of eight of the leading national medical bodies, was put into operation three years ago to revitalize and strengthen this major work to which the National Committee dedicated itself from the very beginning. New surveys of public mental hospitals have been made in forty of the states, in most of which active steps have been taken to raise the standards of service and bring them more into line with existing needs. In this work the National Committee has enjoyed the coöperation, as never before, of such organizations as the American Psychiatric Association and the U. S. Public Health Service, the latter exemplifying the great growth of government interest and activity in the mental-health field in recent years. As a result, we shall undoubtedly see the assumption of large responsibilities for mental-health work in connection with the National Health Program now in the making, with its proposed extension of federal aid to the various states.

The past eight years have seen the sustained support of child-guidance work throughout the country, the continuous growth and development of community organization for mental-hygiene work, and the extension of this work to the schools. A new departure, in this connection, has been the school-studies experiment undertaken by the National Committee, with special reference to teacher training and selection, studies of the mental health of teachers, of classroom practices and so on. To further this work the National Committee publishes a special mental-hygiene magazine for teachers, *Understanding the Child*.

These are only a few high lights of an impressive record of solid achievement that testifies to Dr. Hinck's vision and enterprise in directing the National Committee's work during these trying years. We find it conforming with remarkable fidelity to the aims and purposes he outlined for himself and the organization when he assumed office. Looking at the record more closely, we also find it conforming to the sound policies and goals of his predecessors, but carrying forward their logical development along new lines, venturing into virgin fields and making the most of the opportunities that came to him. The National Committee has gained greatly from the very exceptional qualities that Dr. Hincks brought to his accomplished tasks and feels greatly strengthened, thanks to him, as it rounds out its third decade of work. It especially appreciated his rare capacity to make friends, and to enlist the interest, coöperation, and support of foundations and funds, of scientific and professional workers, of organizations and individuals, of persons in all walks

of life with whom he pleaded the cause of mental health. Immeasurably he enlarged and multiplied our contacts in every direction, by his effective spokesmanship, his earnestness, his good humor, his warmth of personality, his diplomacy and charm. The National Committee and the mental-hygiene movement in this country are greatly in his debt, and in relinquishing him to the rightful claim of Canada, after eight years of delightful association with him on "borrowed time," we wish him and the Canadian mental-hygiene movement a prosperous future and the best of good fortune.

The New Medical Director

Dr. Stevenson comes to his new post as medical director exceptionally equipped for the duties and responsibilities of this exacting position. The high regard in which he is held by mental-health workers the country over is borne out by the numerous letters received by the board of directors advocating his appointment, and by the striking unanimity of their praise of his wide knowledge and thorough grasp of the field, technical skill, sound judgment, and admirable personal and professional qualifications.

Dr. Stevenson was born in Philadelphia in 1892 and received his early education in the public schools of Vineland, N. J. He graduated from Bucknell University with a B.S. in 1915, returning to that institution for his M.S. in 1919. He received his M.D. from the Johns Hopkins Medical School, interning at the Henry Phipps Psychiatric Clinic from 1919 to 1920. Trained under the best men in his profession, he secured a thorough grounding in medicine and psychiatry and followed this up with a varied experience in hospital and clinic work, in teaching and research, and in community work. He was assistant in neuropathology at the New York State Psychiatric Institute, 1920-22; clinical instructor in psychiatry at Cornell Medical School in 1920-22, and 1929-34; research psychiatrist at the Training School at Vineland, 1922-24; assistant professor of psychiatry and director of the state clinic, University of Minnesota, 1924-1926; and attending neurologist and psychiatrist at the Minneapolis General Hospital, 1925-26, leaving that institution to join The National Committee for Mental Hygiene as field consultant for the Division on Community Clinics, of which he became director in 1927.

Dr. Stevenson "grew up" with the child-guidance movement, his thirteen years of service in this field being coterminous with the period of its greatest growth. To write an account of his work and achievements during this time would be, in effect, to write the story of the phenomenal development of child-guidance work in this country. The Commonwealth Fund, which so liberally financed this work and played a leading rôle in the rise and development of

child guidance, through grants to our National Committee and in other ways, commissioned Dr. Stevenson, with Geddes Smith, to write this story, which it published in 1934, under the title *Child Guidance Clinics: A Quarter Century of Development.*

A unique achievement of the child-guidance-clinic movement, apart from its own specialized contribution to the study and treatment of conduct disorders in children, has been the way in which it has marshaled and coördinated the various community forces that have been brought to bear on guidance work with children. Dr. Stevenson cultivated this field and acquired a competency and eminence in it such as to earn for his division its acknowledged authority as the national consultation bureau for child-guidance work. He became the expert in "community diagnosis," who, with Miss Clara Bassett, went across the country surveying and appraising the medical, educational, and social resources of many of our cities, upon which the effective organization and functioning of child-guidance-clinic services have come to depend. Tracing the intricate pattern of professional and public relationships that form the basis of effective community coöperation in child guidance, one of his important functions has been to keep the development of clinic work on a sound basis, and standards of technical work and training on a high level. This work of the National Committee will continue under the personal direction of Dr. Stevenson, with a psychiatrist as full-time assistant.

The American Orthopsychiatric Association recognized Dr. Stevenson's contributions to this field by electing him as secretary for several successive terms, and as president of the organization in 1934–5. He is Chairman of the New York City Committee for Mental Hygiene of the State Charities Aid Association, and a member of the Executive Committee of the Society for Research in Child Development, of the Executive Committee of the National Conference of Social Work, and of various other mental-hygiene committees. He is also a member of the American Psychiatric Association, a fellow of the American Medical Association, and a member of the Central Neuropsychiatric Association, the Minnesota Neurological Society, and the American Association on Mental Deficiency.

The Challenge of Mental Health and Disease

The challenge of mental disease was the subject featured by the American Association for the Advancement of Science at its One Hundred and Third Meeting, held in Richmond, Va., December 27-31, 1938. This fact, as the New York *Herald Tribune* pointed out in its report on the meeting, "is significant of the times and hopeful for the progress of one of man's darker and more difficult

battles with his fate.'' No longer is this most complex among the major problems of medicine regarded as one apart and remote from the interests of science, nor the exclusive concern and domain of the psychiatrist or neurologist. The Symposium on Mental Health, conducted by the Association's Section on Medical Sciences, under the sponsorship of the American Psychiatric Association, the U. S. Public Health Service, The National Committee for Mental Hygiene, and the Mental Hospital Survey Committee, demonstrated conclusively that all the medical and biological sciences have a stake in the problem. Never before, to our knowledge, have the representatives of so many sciences and disciplines been brought together in a psychiatric or mental-hygiene conference, with such good effect and such promise of further inter-scientific collaboration in the study and treatment of the mental disorders. Participating in the program were physiologists, biochemists, biologists, geneticists, epidemiologists, psychiatrists, neurologists, and other medical specialists; and on the non-medical side, sociologists, psychologists, criminologists, anthropologists, economists, educators, and political scientists.

The conference was one of the most interesting and productive, and one of the most unique of its kind, ever held. A committee of outstanding psychiatrists, under the leadership of Dr. Walter L. Treadway, who conceived and planned the project, spent a year or more in preparation for the event. The pre-publication of most of the papers was a new note in the symposia held by this section of the Association in recent years, of which the Symposium on Mental Health was the tenth, and the first to deal with this broad subject. The symposium sessions consisted primarily of summaries of these papers, by their respective chairmen, and of formal and informal discussions of their subject matter. The program ranged over the whole field of mental health, covering some seventy topics, which were, however, selected with a view to focusing the discussions on fundamental issues. It was in the best sense a scientific forum, a valuable aspect of which was the wide public attention it commanded in the daily press, thanks to the admirable reporting of the symposium sessions by trained science writers and to the capable work of the Association's public-relations committee.

As the proceedings of the symposium will shortly be published in a special volume to be issued by the A.A.A.S., no attempt will be made here to report the individual papers and discussions. (A further announcement of this publication will appear in the next issue of this journal.) We present only the conclusions and recommendations of the session chairmen, which epitomize the more basic aspects of the discussions and clarify the main issues and problems

confronting workers in the mental-health field today. The discussions of the symposium have thrown new light on the questions and problems engaging present-day scientific thought in this field, have opened up promising avenues of further investigation and study, have suggested fresh approaches and, in some respects, have brought about a new orientation toward the whole subject of mental health and disease. In addition, they have had the very practical purpose of laying down a base line for the next phase in the attack on this great problem, of outlining an effectual plan and program for our future course. We are on the threshold of new and significant developments in this field, when clear thinking, wisdom, and statesmanship, as well as scientific knowledge, are required as never before. The symposium, we believe, is a timely contribution in this direction.

As Dr. Treadway pointed out, the problem calls for a union of scientific and social effort in a concerted, coördinated, and more effective attack on mental disorders and disease than heretofore. "Mental illness is a national problem," said Dr. Treadway, in summing up the aims and purposes of the symposium. "Its solution must also be national in scope. Hence the need for an alliance of the medical, scientific, educational, and social forces of the country that can contribute, in one way or another, to its solution. Every strategic national agency, public and private, whose resources can be brought to bear, must be enlisted, under the leadership and banner of medicine, in the fight on this great public-health problem. Some of these agencies will be better able to perform certain specific functions than others. All of them together, through a cohesive alliance of forces and coördinated planning and organization, can exert a constructive influence on this many-sided problem."

Session I

PSYCHIATRIC RESEARCH

Summary and Conclusions

By Nolan D. C. Lewis, M.D., *Session Chairman*

The importance of research to medical progress is everywhere recognized. Without painstaking investigation into the nature and causes of disease, the brilliant achievements of the medical and sanitary sciences in the control and conquest of the scourges and plagues of past centuries would not have been possible. This is especially true of scientific accomplishment in the treatment and prevention of physical disorders in man, but it is no less important in the realm of mental disorders, when we consider the magnitude and scope of these disorders and their far-reaching human, social, and economic consequences. Scientific progress in this field has lagged, in comparison with that in other

fields of medicine, due largely to its traditional neglect by the medical profession. Happily, the outlook is changing, and the possibilities and promise of mental medicine are commanding the serious attention of the various biological and medical sciences.

The Crucial Need

Despite the far-reaching advances in the treatment of the mentally ill in the past few years, patients enter mental hospitals in greater numbers than they go out, and we are faced with the prospect of a progressive increase in hospitalized mental disease, necessitating the constant enlargement of institutional facilities, unless more effective programs of prevention and treatment can be developed. For this we need additional knowledge concerning the nature and causes of mental disease, which only sustained and systematic scientific investigation can give us. Research in this field must be extended and accelerated if we are to reverse the present trend and bring the ever-widening incidence of mental disease under control.

Promising Developments

There are promising indications of more rapid progress in psychiatric research in the future, as shown by the discussions at the Symposium on Mental Health; and the noteworthy developments in scientific knowledge, reported here, justify the hope of further significant advances. A recent national survey reveals research activities of an impressive character under way or projected in a considerable number of tax-supported mental hospitals, and possibilities for research in many more, as well as the existence of a genuine interest in scientific investigation and an array of research talent that await only modest encouragement and support to be productive.

Retarding Factors

The chief deterrents to the more vigorous prosecution of research in public mental hospitals at the present time are inadequate staffs, remuneration insufficient to attract the best workers, inferior clinical standards, difficulty in securing appropriate facilities, and lack of funds for investigative work. Notwithstanding these handicaps, there is evidence of much creditable work, a large degree of individual initiative, and a commendable scientific spirit, but also much ineffective activity, a scattering and duplication of effort, and other limitations due to lack of coördination, continuity and organized planning.

Research as a Public Policy

There is urgent need of greater and more consistent recognition of psychiatric research *as a matter of public policy,* since of the large amounts of public money appropriated for institutional maintenance in the several states only a negligible fraction is now available for scientific study. This is all the more imperative since it is in our tax-supported institutions, which care for the great majority of the mentally sick in this country, that such investigation and study must be encouraged and developed, if we are to reduce the enormous burden of uncured and untreated mental disease. Economic and scientific considerations alike dictate the wisdom of such a policy, and state governments, backed by an enlightened public opinion, must be induced to devote a greater share of the mental-hospital tax dollar to the promotion of research efforts. Such research activities are of great value not only for the advancement of scientific knowledge, but for the stimulus they afford to better clinical work and the improved care and treatment of patients.

State Hospitals as Research Centers

At least twenty of our public mental hospitals are conspicuous for the amount and quality of their scientific work, and some thirty others show evidence of a potential capacity for research work. Steps should be taken without delay to capitalize the now neglected opportunities for scientific advancement in state hospitals, with their abundance of clinical materials, by strengthening the existing research centers, in order to facilitate the recruiting and training of research workers for the potential group of research centers which possess the basic facilities that lend themselves to the conduct of scientific work and require only the laboratory equipment, technical personnel, and other necessary arrangements to make the most of their possibilities.

Financial Needs

A vital factor retarding the more rapid development of research activity and interest in public institutions for the mentally ill is the unequal distribution of economic resources available to the several states. From the standpoint of the national welfare it is desirable that the federal government, the various funds and foundations, public-spirited citizens and industry should assist the states and municipalities in developing psychiatric research, through subsidies for the creation and extension of research facilities in public and private mental hospitals and clinics at strategic centers, by grants-in-aid for research fellowships and training programs, and by other suitable means.

Inter-Scientific Collaboration

Scientific progress in mental medicine depends also on the closer linkage of mental hospitals with medical schools and university centers, to the end that the various sciences and disciplines may more effectively contribute, by their special knowledge, resources and techniques, to the advancement of study and research in this broad field. A greater measure of financial assistance should be available to medical schools and universities for this purpose. A collateral need is for the formation of a consultant and advisory body to plan, organize and coördinate research activities and interests and to guide workers in this field, and for the establishment of a bibliographic service to supply abstracts of the current literature on all phases of this subject.

Session II

SOURCES OF MENTAL DISORDER AND DISEASE

Summary and Conclusions

By Abraham Myerson, M.D., *Session Chairman*

It is apparent from the evidence submitted and discussed in this Symposium that there are sources of mental diseases and disorder in the American community which, by the application of modern techniques, scientific knowledge and social effort, may be ameliorated and uprooted. Certain of these sources are due to innate factors, others are of external origin, involving infections, drugs, food deficiencies, and social and cultural mishaps; and they are, to a great extent, modifiable from the standpoint of prevention, treatment and control. Society looks to the science of medicine for knowledge in these matters and for guidance and leadership in the application of this knowledge; but the responsibility for

the development and administration of a concerted and coördinated attack on this problem rests not only on medical science, but on the other sciences and disciplines, and especially on social institutions, agencies, and organizations.

The Genetic-Constitutional Mental Disorders

First and foremost are the large groups of mental and nervous disorders of the constitutional and hereditary type. These present the greatest difficulty from the standpoint of causation and treatment, education, and social action. They represent a major problem of research in mental medicine. While in the present state of our knowledge of the operation of heredity in mental disorders it is not possible to devise long-range programs of prevention, enough is known regarding the nature and causes of some of these disorders to warrant the adoption of certain measures of remedial, hygienic and eugenic value. Among these are, first, the enactment of more adequate and more uniform marriage laws looking to the prevention of precipitous and ill-considered matings, and the requirement of suitable pre-marital medical examinations and due public notice of intention to marry. Second, the conservative practice of voluntary selective sterilization, as a therapeutic, euthenic, and eugenic procedure, to be applied to well-considered cases, with a view to individual and social adjustment as well as race betterment; and the enactment of suitable legislation to this end, with due regard to the establishment of proper cautions and safeguards against the abuse of such practice. Third, the extension and support of general programs of human betterment looking to the amelioration of social, economic, and other environmental conditions and factors that are conducive to mental and nervous disorder and disease.

Syphilis

Syphilis is a preventable cause of much mental as well as physical disorder, and is slowly yielding to study and treatment, because the source and remedy are definitely known. Early detection and prompt and prolonged treatment in the individual case is the only safe method of curing the disease once it is acquired. But effective control and prevention of the disease depend on systematic and widespread prophylactic and educational effort. Its ultimate eradication calls for wholehearted and vigorous public support of the current nation-wide anti-syphilis campaign which promises to eliminate one of the major sources of lethal mental disease.

Alcoholic Mental Disease

Science has taken up the challenge of this age-old problem. It has demonstrated that alcohol is a narcotic drug, not a stimulant. It has shown the relationship between vitamin B_1 and C deficiency on the one hand, and injury to the nervous system on the other, a relationship of far-reaching social and psychiatric importance. There is imperative need for a new educational campaign, based on the best available knowledge of the nature and causes of the problem, to reduce and control excessive drinking and its injurious effects on physical and mental health. Special institutional and clinical facilities are urgently needed for the study and treatment of individual cases. Fundamentally, however, we need a constructive and enlightened public policy and approach looking to the mitigation and control of chronic alcoholism, by cultivating correct public attitudes, by the promotion of adequate legislation with reference to licensing and other restrictive measures, and by subordinating commercial and revenue-producing motives to broader considerations of the public health and welfare. Public education, in the last analysis, is our

strongest weapon, and the legal, medical, and social forces of the country must unite in a concerted program and effort to cope more effectively with this potent source of major and minor mental disorders.

Deficiency Diseases

In its search for causes and remedies, science has found that the healthy mind is dependent on such matters as proper and adequate nutrition. We stress particularly the significant relationship of vitamin deficiency to pellagra, which is a mental and physical disease endemic in certain areas of the country. The obvious need here is for the free distribution of vitamins and proper and adequate food in these underprivileged districts, in order to cure and prevent the disease. A large part of the American population is not optimally nourished, and in so far as proper diet can prevent mental and physical ill-health associated with the deficiency diseases, it is incumbent upon the public and private agencies of the country to work for adequate nutrition and for the modification of social and economic factors responsible for malnutrition and undernourishment wherever they exist.

Immigration and Mental Health

Migration is doubtless an important though little understood factor affecting the mental health of American communities. The subject requires further study in the light of contemporary world conditions and the complex factors of modern civilization as they bear on human adjustment. Restrictive immigration measures cannot be soundly based on narrow concepts of race or nationality, nor on purely economic considerations and motives, but must also consider the ethical and cultural values of immigrant groups that seek to enter the United States from neighboring and distant countries. Hence the importance of evolving a wise and effective policy and program of selective immigration looking to the mandatory exclusion of the mentally unfit and the conservation of national mental health.

Child Placement

The proper placement of dependent children is a social measure of prime importance to the preservation of mental health. Because of the conserving values of family life, society owes it to foundlings and to the children of improper homes, and to itself, to distribute them to good foster homes. Special attention must be given to the needs of mentally handicapped children and those presenting behavior problems, to the end that the placement of such children be in accord with principles and practices that seek to protect the child on the one hand and the family on the other. Measures must also be taken to guard against the danger and menace of exploitation and abuse in inter-state migration of mentally defective and delinquent children. Hence the importance of adequate state laws and regulations governing child placement and adoption, and the adequate supervision and control vested in the appropriate authorities in the various state and local jurisdictions.

Research

Finally, and of major importance, is the need to intensify and extend scientific investigation of the phenomena of mental disorders, and to determine where, when and under what conditions such disorders occur, with a view to more effective therapeutic and preventive work. The various research groups working on this problem throughout the United States need a closer integration and a pooling of resources, so that a better coördination of effort may lead us to a more successful attack on the total problem of mental health and disease.

Session III

ECONOMIC ASPECTS OF MENTAL HEALTH

Summary and Conclusions

By Joseph Zubin, Ph.D., *Session Chairman*

Mental diseases are among the most widespread, the most disabling and, in their personal, social and economic consequences, the most serious in the whole category of diseases, occupying more hospital beds on any given day in this country than all other diseases combined. Affecting all social strata, they are a pervasive and debilitating influence in our national life, causing much suffering and misery and entailing enormous loss in terms of institutional maintenance, drain on public and private funds, reduced earning power, family disorganization, and other financial and human costs. In dealing with a public-health problem of such dimensions we must necessarily give consideration to the economic factor, operating both as cause and effect, in its general and specific relationships to all aspects of the problem.

Inadequate Facilities

A primary cause of our relative failure to cope with the problem up till now has been the all-too-limited and restricted provision we have made for the care and treatment of the mentally ill. Large sums have been spent for institutional care of the end results of mental disease, on bricks and mortar and other elementary requirements of an urgent physical nature, but not enough on the right types of clinical and treatment facilities and measures to meet the varied medical needs of this class of the sick, and in proportion to their numbers. The underlying difficulty has been the failure, in most of the states, to adopt far-visioned, comprehensive plans and programs with long-range objectives looking beyond the pressing needs of the moment to the more fundamental requirements of well conceived and effectively administered therapeutic and preventive measures to deal with the problems of mental illness at their most vital points and at their source. In their more hopeful and constructive aspects, these problems have been comparatively neglected, due to inadequate and short-sighted public policies that are themselves responsible, in great part, for the present financial burden of mental disease.

Economics of Care and Treatment

While the amounts appropriated for mental hospitals are not in themselves an indication of the value of the hospitals or of the character of treatment their patients receive, a higher per capita outlay is necessary for proper diagnostic treatment and preventive services and is, in the long run, more economic than a low per capita cost for prolonged custodial care. The most costly way is the inadequate way. A wise spending policy calls for the financing of well-chosen and well-directed measures looking to the reduction of admissions to mental hospitals, the reduction of time spent by patients in hospitals, and the increase of recoveries and discharges. The improved management of the mentally ill and their more rapid restoration to normal life will require effectually a reorganization of our state-hospital systems, calling for the progressive abandonment of merely custodial care, increasing emphasis on intensive study and treatment of the recoverable types of mental disease, and the provision of separate accommodations of a domiciliary character for the less hopeful cases requiring prolonged care.

Community Organization

It is apparent, moreover, that the needs of the mentally ill cannot be adequately met by the mere expansion of institutional facilities to house the increasing numbers of mental patients; that the building of more and larger mental hospitals cannot continue indefinitely; and that the answer to the problem, both from the standpoint of medical requirements and economic feasibility, must lie in the development of new types of social machinery and in community organization and planning. Indeed, the amelioration and control of mental and nervous disorders require a new orientation and approach if we are to deal with these disorders more effectively and more economically. We must embark on large-scale programs of treatment and prevention calling for the widespread establishment of out-patient and social services, psychiatric departments in general hospitals, university psychopathic hospitals, mental-hygiene clinics for children and adults, professional and public education, demonstration and research, and other community services of an ameliorative, therapeutic, and prophylactic nature.

Family Care

Experience abroad and in this country indicates that boarding-out systems, or family care of the mentally ill, may serve as a partial solution of the economic problem associated with mental disease, by reducing the excessive burden of institutional care. Special attention should, therefore, be given to experimentation looking to the extension of this type of care and treatment on a nation-wide scale. This will require, among other things, educational effort to mold public opinion in favor of such a system, to the end that American communities may assume the responsibility and obligations involved and coöperate with the public authorities, on the principle that family and community life and normal human relationships are a conserving force for emotional security and conducive to the cure of the mentally ill as well as the protection of mental health among the general population.

Federal Aid

The adoption of such measures as have been advocated above will call for an enlightened budget policy, and the states and municipalities must be encouraged to develop their resources to meet these obligations. To the extent that it is necessary and temporarily expedient, the aid of the federal government should be invoked, particularly with reference to the need for investigation, experiment, and demonstration, and to fortify and support state and local efforts to establish the requisite facilities for effective work along these several lines.

Mental Factors in Physical Disease

In all the above we are concerned with the many and diverse forms of mental diseases and their primacy as an institutional and public-health problem, tremendously burdensome on the nation's economy, especially from the angle of public taxation. They are economically significant also in relation to the general diseases. Medical experience amply shows that mental and emotional factors play a large rôle in physical disorders of various kinds, frequently complicating diagnostic procedures, prolonging hospital care and promoting invalidism, thus adding to the economic burden of disease in general, through failure properly to deal with and treat these factors.

Social Security

Conversely, there is strong presumptive evidence that unemployment, inadequate incomes, poor housing, and other economic, social, and environmental con-

ditions contribute significantly to the production of mental and nervous disorders, and that an adequate approach to the problem of mental disease in its wider reaches and ramifications must take into consideration the general problems of our industrial economy. Social-security programs must therefore include such measures and objectives as will contribute to the reduction and prevention of mental and nervous disorders and the conservation of mental health, by ameliorating the mental and emotional hazards of economic disability, insecurity, and dependence. At the same time the federal and state governments must be cautioned and advised to adopt suitable safeguards, in connection with the social and health-insurance features of social-security programs, by providing for adequate diagnosis and treatment of mental and emotional as well as physical conditions and factors in economic disability.

Session IV

PHYSICAL AND CULTURAL ENVIRONMENT

Summary and Conclusions

By Harry Stack Sullivan, M.D., *Session Chairman*

A person is more than a product of heredity and biophysical environment. He is very significantly a product of his experience with other people, with the conventions and traditions they represent, and the institutions to which they accommodate themselves. His career from birth to death may be viewed as a progression through a physical-cultural world, but its direction, its vicissitudes, are largely determined by events in his relations with the people who are significant to him. This is the case in the more successful living that we call mental health, just as it is the case in failures of progression as a social being, which we call mental disorder in some cases, crime in others. It is possible to discover in actual life histories congeries of factors that have made for success in living, continued or improved mental health; just as it is possible by similar study to uncover events that have increased the difficulties of living, and made more likely or actually precipitated frank mental disorders.

Psychiatry and the Social Sciences

Both the social sciences and psychiatry have been relatively sterile in the practical direction of human affairs. The mental-hygiene movement has corrected many abuses in the case of those who fail; child guidance and the psychiatric repercussions in education have saved many from more serious warp. The debit side of the ledger is not as red a picture as it was fifty years ago. On the credit side, however, the sum total of positive constructive changes in the fabric of society is woefully small. The instrumentalities of psychiatry and the social disciplines have been unsuited to ready use by legislator, jurist, and statesman, not so much because of technical abstruseness as because of inherent narrowness and overspecialization of purview. Hope for the general conservation of mental health would seem chiefly to reside in a pooling of the techniques available in the social and the psychiatric disciplines, a redefinition of the fields to be explored, and a vigorous support of research into the currents of social change and personal experience, so that we can rapidly discover relationships that make for the healthy expansion of personality and the effective collaboration of people. This session of the Symposium has been chiefly useful

as an indication to psychiatrists of some few of the types of help that could come from anthropology, sociology, political science, psychology, and statistical analysis.

Collaborative Investigation

The cultural anthropologists study the broad outlines of living in the varied social situations within which different peoples find themselves "at home." In the case of a people, for example, who are absorbing foreign culture, and where there are cultural conflicts, many illuminating phenomena are to be perceived. One can study the incidence of mental disorders and crime in relation to the personal careers from the family acculturation through the more formal educative institutions into adult rôles. The data from the career-lines of people maturing in a setting of rapid social change are most important for the elucidation of conservative and malignant influences on personality that inhere in the personal environment. By collaborative study, psychiatrists interested in interpersonal relations and anthropologists interested in culture can, first, get to understand the more subtle implications for each other of phenomena of this kind; and secondly, can evolve *valid* frames of reference for the study of our own culture-complex as to its conservative and malignant influences on the mental health of our peoples. A great part of our current sociological exploration of the American scene is invalidated by the investigator's unwitting preconceptions, against which this comparative approach is an indispensable precaution. Another difficulty is that arising from confusion of terminology as between the various disciplines. Collaborative investigation and broader technical equipment is something quite different from verbal dexterity, which takes too much for granted about language and linguistic phenomena. There should be a good deal of respect for formal clarity and the processes of interpersonal communication.

Cultural Anthropology

The cultural anthropologists are perhaps less baldly confusing, if only from their training to respect linguistic processes and language. The contributors to this Symposium have marshaled technical data in lucid reference to clearly formulated problems of the psychiatrist interested in personality. One of them brings out clearly the significance for conserving mental health of factors inhering in our economic structure. Great as are the hazards of emotional warping in childhood, as he points out, it is often the economic hazards encountered in life as an adult that precipitate personality disorder and crime. Another anthropologist questions the "inevitability" of our prevailing mental disorders and delinquency, and pertinently asks whether we might not profitably turn to an overhauling of our heritage of traditions and institutions, rather than go on making provisions for ever-increasing numbers of mental invalids.

Social Psychology

The social psychologist, in these discussions, has talked to us about the "organism-in-an-environment" and the new methods of study oriented to this concept. He posits the questions of how the environment impinges upon the particular individual, how its forces become an integral part of the particular personality concerned, and how that personality, in turn, influences and modifies the relevant environment. He speaks of the "delimitation of *the personal environment.*" For each individual in a community, he points out, the community is different, presents particular relevant aspects. By inference, he raises the highly significant question: Does not adherence to the accepted methodologies, especially the emphasis on quantitative studies, tend to exclude from study those

very aspects of the environment that are of the greatest significance for mental health?

Social Statistics

In the field of social statistics we have studied, specifically, the subject of internal migration. Internal migration is of mounting significance in America and an appraisal of the factors at work in the process has much relevance to any program of mass mental hygiene. Migrants, we have learned, are to be viewed as people who are seeking adjustment by leaving one environment and going to another, and migrants may be possessed of better qualities than are non-migrants. We must study those who have migrated, as well as those who have stayed at home, if we are to be certain of the validity of our conclusions as to the effects of early environments. This factor enters also into efforts at appraising the effects of persons on communities as personal environments.

Sociology

From the sociologist we have secured new insights into the social structure of the mental hospital, considered as a segregated community. His account of the processes at work there is most significant to the psychiatrist in its utilizing of conceptual frameworks that give new depth and meaning to his institutional experience. We have learned that a particular type of social structure may be good for some persons, but not for others; that the mental hospital, along with some other segregated communities, is distinctly and necessarily different from the community at large. The sociologist has pointed out how its specific differences are useful in restoring mental health and has provoked us to wonder how this pattern of the segregated community might be usefully extended in our democratic state.

Political Science

The political scientist "looks at" psychiatry and ponders situations wherein the data of psychiatric study may yield a "political therapy." He challenges psychiatry to help those who would take over the control of "integrative politics" from those who lack insight and understanding of human needs; to employ its new-found knowledge of interpersonal relations in aiding in the direction of human affairs and countering the waves of propaganda and prejudice that block efforts at a scientific reform of our national life. In "political psychiatry" he sees possibilities for the liquidation of destructive tendencies which underlie general insecurity and discontent. Conversely, in reviewing the history of psychiatry, he shows the utility to psychiatrists of the techniques and viewpoints of political science.

Man as Man

This session of the Symposium has taught us that we must study people as people, in the setting of the times and in their actual social-cultural environment, if we are to uncover the factors that make for failure and mental disorder on the one hand, for success and mental health on the other. There are many fields of data to be covered, many complex factors to be uncovered and assessed. The exploration calls for scientists who are intensely interested in man and his actual conduct among men and man-made institutions, not in parts of the human body nor yet in pale abstract formulæ about people, or money, or work, or play. The scientists who will contribute most to these investigations will have rather broader training than has the average contemporary psychiatrist or social scientist. They will combine much that is best in the conceptual frameworks of these disciplines with powers of participant observation greatly enhanced by specific training to those ends.

Session V

MENTAL HEALTH ADMINISTRATION

Summary and Conclusions

By Clarence M. Hincks, M.D., *Session Chairman*

The care and treatment of the mentally ill and the mentally defective in this country have long been recognized as an appropriate function of the state. It is increasingly obvious, however, that in many of the states this function has not been or cannot, under existing conditions, be adequately discharged. Authoritative studies show that no legislature has kept pace with the needs of the mentally ill and defective, that in but few of the states do public mental hospitals even approximate the minimum standards advocated by the American Psychiatric Association, and that there is no uniformity in public policy and procedure among the states in respect to provisions for this class of the sick. Such provisions as there are have been made, by and large, as a matter of expediency, to meet pressing emergencies, without regard to the requirements of an adequate and balanced medical and social program. Instead of a systematic plan of hospitalization, based on the varied needs of all the mentally ill, we find a haphazard development of piecemeal facilities and measures, totally inadequate to the needs, with the result that every stage in the evolution of the care and treatment of this group is represented somewhere in the United States to-day.

Central Administrative Organizations

It is recognized that the care and treatment of the mentally ill is essentially a medical problem and that the responsibility for guidance in the formulation of mental-health policies and programs and their administrative direction falls necessarily and primarily on the medical profession. It is apparent, also, that the adequate discharge of this responsibility and the carrying out of such policies and programs require the organization and maintenance of strong and efficiently administered central state agencies, under the direction of competent medical executives specially trained in this branch of medicine. This is basic to the whole question of proper care and treatment, as we have seen from our survey of the present administrative structure in this field.

Professional Merit *vs.* Politics

A corollary to the requirement of sound central state administrations is the necessity of defending them against the evils of adverse political control, interference and exploitation, so rife in many state jurisdictions to-day. We find that the states do not maintain the necessary safeguards, as to employment and tenure of office, to protect public servants engaged in this highly specialized field and the patients entrusted to their care. The obvious remedy is the establishment of carefully constituted, non-partisan boards of control, the enactment of civil-service laws and regulations, and other protective devices, to the end that professional competence and merit only and not political considerations may govern in determining qualifications for appointment in this work.

A Comprehensive Public Policy

There is patent need for the development of sound, progressive, more comprehensive, and more uniform public policies and measures for the care, treatment and training of the mentally ill and mentally defective throughout the country. Many of the state jurisdictions do not at present take into account the need for more adequate treatment facilities to provide for various types of

cases. The provision of beds for the bare needs of the more urgent cases, as we have seen, has come to be regarded in many sections as the sum total of a state's obligations toward its mentally ill and defective wards. The early recognition, treatment, and prevention of the many and diverse forms of mental disorders require not only the provision of more suitable and more adequate hospital and institutional facilities, but also broad-gauged, carefully planned programs of community organization calling for extra-institutional activities and measures of an ameliorative, therapeutic, and prophylactic nature.

Intensive Treatment Services

An immediate and outstanding need is for the improved organization and extension of medical services in public mental hospitals, with special reference to the recoverable types of cases. Every state hospital should have a modernly equipped and adequately staffed reception unit for the intensive study and treatment of newly admitted patients, in an effort to return as many as possible to their homes in a cured or improved condition, and in the shortest possible time. The first eighteen months of residence in a mental hospital are the most crucial period as to prospects of cure—when, under the right conditions, many of the acutely ill respond to treatment and may be expected to recover. Because of the relatively expensive character of such provision, with its special requirements of material facilities and professional services, it is desirable that the budget and cost accounting for intensive treatment services be kept separate from that for the prolonged care provided for patients in other hospital units. Some such breakdown of clinical groupings would seem to be indicated in the future organization and development of public mental hospitals for greater therapeutic and economic effectiveness. While such arrangements will make for economy in the long run, they will require initial outlays that most state and local jurisdictions can probably not afford to make in the present state of their finances. Under the circumstances, federal aid in some measure, through subsidies or loans or both, to supplement state or local resources, seems to be necessary. Such federal assistance, with suitable safeguards, over a stipulated period and until such time as the states and municipalities can assume the full burden, would enable them to improve and develop their mental-hospital services to a degree not otherwise attainable under present conditions.

Community Programs

Equally important is the expansion of community mental-health services. Every state hospital should serve as a nucleus for diagnostic and preventive treatment services for the patients in its district who do not require institutional care. It should function as a center and focus for the development and guidance of community programs calling for clinic services for children and adults, and for coöperation with local practitioners, medical, social, educational, and legal agencies, and should furnish psychiatric leadership looking to the control and prevention of mental disorders. The prospect of federal aid would similarly serve as a stimulus to state and local governments in promoting these broader aspects of mental-health work.

Public Health Departments

Mental diseases being a public-health problem of recognized major importance, it is logical that we should look to the regularly constituted health agencies of the country to share responsibility for the study and control of these diseases in their respective state and local jurisdictions. Our public-health departments

can contribute significantly with special reference to the various modifiable or preventable factors in mental disease, by broadening their outlook and approach in this field, by developing an "endemiology" of mental disease and devising methods of community diagnosis and study, and by integrating their knowledge and techniques with those of psychiatry, sociology, and other scientific disciplines engaged on the problem. Leaving to the established agencies that minister to the clinical needs of the mentally ill the responsibility for the treatment of the individual mental patient, the health department can engage in those activities that seek to control and prevent mental diseases in the mass and to promote positive mental health.

Statistical Studies

Sound work in this field depends on accurate knowledge of the extent and character of our problem. Hence the importance of well-organized and properly conceived statistical studies. Every state should set up and maintain in its central administrative organization a statistical unit for the enumeration of patients in mental hospitals and the analysis of mental-disease incidence, trends, movements of population and other comparative data. It is recommended, in this connection, that the Federal Census Bureau enlarge its functions in this field by establishing and defining registration areas for the systematic reporting of mental illness; and that the American Medical Association take for its province the collection and study of comparable statistics dealing with the institutional, administrative, and economic aspects of mental diseases, and their interpretation to the medical profession and the general public.

Technical Advisory Services

We have seen that administrative organization and practice in the care and treatment of the mentally ill and defective in the several states suffers from lack of a well-defined and consistent national policy, resulting in an unequal development of public provisions, with standards varying widely from state to state. As a corrective, it is proposed that the federal government, through the Public Health Service and in collaboration with the American Psychiatric Association, The National Committee for Mental Hygiene, and allied voluntary agencies, set up and maintain a technical advisory and consultant service, to serve as a clearing house of information and as an aid and guide to state and local jurisdictions in promoting sound principles and practices in the whole diversified field of mental-health administration.

Uniform Laws

As one consequence of the lack of national coördination, we cited in our discussions the great diversity of state laws and regulations governing the admission of the mentally ill and defective to public and private institutions in this country. These provisions should be such as to facilitate easy admission and discharge, with a minimum of formal legal proceedings, but with due regard for the rights of the individual and society. Reforms are even more urgently needed in legal procedures involving the mental examination of criminal offenders, to the end that the existing evils of "expert testimony" may be mitigated or abolished. The laws pertaining to settlement or bona fide residence as they affect public responsibility for the care of mental patients and the costs of care are similarly inadequate. To correct this situation it is proposed that those concerned with mental-health administration should coöperate with the Commissioners on Uniform State Laws and with other suitable agencies in order to bring about greater uniformity among the laws in these various categories, the more adequately to meet the existing needs.

Session VI

PROFESSIONAL AND TECHNICAL EDUCATION

Summary and Conclusions

By Franklin G. Ebaugh, M.D., *Session Chairman*

In this culminating session of the Symposium we have discussed questions that are fundamental to the whole subject of mental health. In a sense this has been the crucial session of the Symposium, since the many issues and problems dealt with in the other sessions ultimately head in here; for the achievement of mental-health goals depends on administration of the many and varied activities and functions involved in our attack on this great problem; and effective administration depends on effective workers. We must have an adequate and competently trained professional and technical personnel to implement institutional and community programs for treatment, research, education, and prevention. This is pivotal to the whole structure of mental hygiene.

Technical Personnel

There is great need for the recruiting and training of psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, occupational therapists, and allied specialists in this field. The available personnel is far short of the requirements at this time. In proportion to the dimensions of our problem, our field is greatly undermanned. But our problem is even more fundamental and goes beyond the development of special personnel to meet existing needs.

General and Mental Medicine

It is now recognized that psychiatry is an aspect of all medicine, as well as a specialty; that mental, emotional, and environmental factors play an important rôle in invalidism and in the etiology, diagnosis, development, and management of all sickness; and that modern biological science, by obliterating artificial distinctions between body and mind, is orienting medicine more and more to a unitary conception of the human organism functioning as an integrated whole, in health or disease, so that the interrelationships between physical and mental disorders are now better understood and the importance of treating the total personality, the patient as well as his disease, is better appreciated.

Psychiatry in Medical Education

In line with this conception of the true function of medicine as the study and treatment of man himself, as well as his organs and cells, we must continue and intensify our present efforts to broaden medical education, by providing the physician and the medical student with a better orientation to these personal and social factors in disease. Psychiatry must be taught as a fundamental discipline throughout the medical course, in its clinical and pre-clinical phases. Graduate and undergraduate instruction in psychiatry must be extended and improved, not only for the training of psychiatric specialists, but for the benefit of the general practitioner, to enable him to deal more effectively with the mental aspects of medical practice, and to contribute to the control and prevention of mental and nervous disorders, by the early recognition and prompt treatment of incipient symptoms of these disorders. Taking a long view of the matter, we perceive this to be the central need.

Psychiatrists

We are faced, nevertheless, with the immediate and pressing need for more psychiatrists qualified for leading positions as teachers, practitioners, researchers,

and administrators. To increase the number and quality of available psychiatrists will, at this time, accomplish more than any other single measure for the advancement of psychiatry. It is desirable that medical schools strengthen and adapt their curricula to meet this need. In the training and selection of students for careers in psychiatry greater emphasis must be placed, in medical and pre-medical education, on the basic biological, psychological, and social sciences and disciplines.

Postgraduate Training

As a further step, it is recommended that the Council on Medical Education of the American Medical Association, the Commission on Postgraduate Medical Education, the American Psychiatric Association, and the American Board of Psychiatry and Neurology and allied agencies collaborate to improve and extend the facilities for postgraduate training in psychiatry and neurology. In view of the long period of training necessary to qualify for the practice of these specialties, and the high cost involved in establishing the requisite training centers, it is hoped that the federal and state governments, foundations, and funds, will assist in the development of such centers, through subsidies for the construction of facilities, and for personal service, grants-in-aid for fellowships, endowment of psychiatric professorships, and other means for the support of postgraduate training programs in this field of medical education.

Psychiatric Administrators

There is particular need for competent psychiatric administrators. Since there are now no organized arrangements for the special training of mental-health administrators, it is recommended that the United States Public Health Service, the American Board of Psychiatry and Neurology, the American Psychiatric Association, the American College of Hospital Administrators, and The National Committee for Mental Hygiene collaborate in the preparation of a suitable plan for the education of psychiatric administrators, that they define methods and standards of qualification and training, and devise ways and means for the establishment of the requisite training facilities.

Psychologists and Allied Specialists

The potential effectiveness of mental-health work, in its various aspects and ramifications, depends on the coöperative participation of psychologists, social workers, and allied specialists, as well as those working in the medical and biological sciences. This is especially true with reference to preventive work in mental hygiene, in which sociological and educational factors play a part. Here particularly functions the psychologist, whose specialized and varied activities, when properly integrated with the psychiatrist's functions, form an important contribution to the conservation of mental health. In this connection there is urgent need for the recruiting and training of social psychologists, for the definition of standards and qualifications for technical work in this field, and for the organization of appropriate training centers, with opportunities for practical experience as well as academic instruction.

Psychiatric Social Work

Psychiatric social service is a firmly established practice in mental-health work, of demonstrated professional and economic value, though not as yet fully appreciated nor employed to the extent that it should be in public mental hospitals. Psychiatric hospital, ward, and clinic administrators must do far more

than they have toward the establishment of adequate social-service departments, staffed with trained psychiatric social workers. In building up an adequate and competent personnel to meet the increasing need for workers in this field, high standards of theoretical and clinical training and the development of psychiatric courses in all graduate schools of social work are required. Indeed, in view of the growing recognition of mental-health problems in everyday life, courses in social psychiatry and mental hygiene should be a required part of the professional training of all social workers. Effective training for psychiatric social work requires also the development of a far larger number of psychiatric clinical centers, with well-trained clinical staffs experienced in social psychiatry. The formulation of essential standards for such training centers will alone stimulate progress in this field. It is recommended that the question of training and standards receive special study by joint committees of the American Association of Schools of Social Work, the American Psychiatric Association, the American Orthopsychiatric Association, and the American Association of Psychiatric Social Workers.

Mental Nursing

Good psychiatric nursing is crucial to effective treatment and management of the mentally ill, and further improvement in mental-hospital administration in this country depends to no little extent on the development of competent nursing staffs. The present level of psychiatric nursing in nearly all of our state hospitals needs to be raised by the employment of more and better trained graduate nurses, in conformance with the minimum standards of the American Psychiatric Association. This will require, among other things, the improvement and enlargement of educational facilities in schools of nursing at the better psychiatric hospitals, and the extension of psychiatric teaching in general nursing schools, to the end that more students may be attracted to careers in mental nursing. It is recommended that the American Psychiatric Association, in collaboration with the National League of Nursing Education and with the aid of the various state education departments, move to consolidate and strengthen existing mental-nursing-school facilities, raise their standards of student training and selection, develop educational criteria, formulate standard curricula for undergraduate, affiliate and postgraduate training in psychiatric nursing, and establish an appropriate accrediting and certifying authority.

Occupational Therapy

Occupational therapy has long been recognized as a tried and proven adjunct of great efficacy in treatment procedures for the mentally ill, and should be more generally employed in the state hospitals of the country. It is also recognized that the technical skill and special knowledge necessary in administering occupational and other forms of activity therapy require training and education of a specialized nature and along diverse scientific and professional lines. There is at present a dearth of activity therapists qualified for work with mental patients, and in view of the increasing demand for such workers in public and private hospitals steps should be taken to develop special educational facilities, under university or other professional auspices, to meet this need.

The Public-Health Nurse

The public-health nurse is in a unique position, by virtue of her community contacts and ready accessibility to the American home, to contribute to the control and prevention of mental disorders. Aside from her treatment work she has a peculiarly educational function to perform that lends itself admirably to

the promotion of mental health, through her instruction of families in the precepts and practices of health and hygiene. This potential capacity of the public-health nurse for community work in mental hygiene must be utilized and developed by giving her the necessary training and preparation, through suitable courses and field work in psychiatry, psychology, social case-work, and allied subjects.

Mental Health at the World's Fair

Mental Hygiene will be represented by an exhibit at the New York World's Fair, which is scheduled to open on April 30, the one hundred and fiftieth anniversary of the inauguration of George Washington as first President of the United States. It is the celebration of this event that has furnished the mainspring and motive of an undertaking conceived and planned on a vast scale to do honor to the heroic figure who more than any other in our history shaped the nation's destinies. But it will do this in a manner worthy of the larger implications of the life and achievements of that figure and the nation he founded, in relation to world history and man's progress upon the earth.

Taking its theme from Washington's first inaugural address on the balcony of the old Federal Hall in New York City, in which he declared the aim of the new government to be the "discernment and pursuit of the public good," the fair will be dedicated to "the advancement of human welfare and the creation of a better and fuller life." It will symbolize the main achievements of man during the past century and a half and, with its eye on the future, will visualize "the world of to-morrow," and look toward the building of a better society in the new era that is before us. It will give us a brilliant panorama of man's multifarious activities in every sphere of life, depicting his marvelous material accomplishments in all their infinite variety and ramifications, but also emphasizing his social and spiritual needs, his cultural and intellectual interests, his problems, his hopes and aspirations, his ideas and ideals. In light and color and sound its numerous exhibits will give us a dynamic, living picture of modern man and his works in commerce and industry, in art and craft and science, in government and human relationships.

In this record of human achievement the health and vitality of the race looms large as a condition of that achievement and as a value in itself—one of mankind's greatest assets. And nowhere is man's genius exemplified to better advantage than in his attainments in the protection and conservation of that asset. In a spectacle of such scope and magnitude it is fitting, therefore, that man's pursuit of health as a vital factor in his life and happiness should be appropriately pictured, as it will be, in a series of carefully chosen, uniquely designed exhibits, to be set up in a specially constructed

Medical and Health Building, to show the progress of the medical and sanitary sciences in the conquest of disease.

Mental health will take its place among these exhibits, emphasizing the next great advance to be made in man's warfare against disease. Medical science has greatly increased the average span of human life, mainly through the control and prevention of the communicable diseases and through improved child care, and its attack now is on the degenerative and constitutional diseases of middle and old age, among them the various mental and nervous diseases. In this sector, medical science is only beginning to be successful, but with increasing promise, as the biological and psychological sciences surge forward in their advancing knowledge of the human organism and its functioning in relation to environment, in health and disease. And in this advance, the great public-health movements of our time, with their emphasis on education in personal hygiene, are an increasingly important factor, from the standpoint of further prolongation of life and the prevention of disease, as well as the more positive goal of better health and a richer life. With the advent of mental hygiene, we have come to look upon quality of life as of as much importance as length of life. Hence the increasing attention of preventive medicine and public-health education to mental and nervous ills and disorders of behavior and personality that militate against a fuller life—"that the mind of man may last as long as his body."

Mental hygiene has come to symbolize the "higher progress" of man's quest for health and happiness and personality fulfillment, by its concern with the one thing that, in his biological, psychological and spiritual background, distinguishes man from the brute, namely, his *mind*—the guiding principle in human behavior. In this sense, mental hygiene is the ultimate expression and final flowering of public health, in which are summed up the spirit and substance of the health education message as conveyed by the various exhibits in the Hall of Man and other sections of the Medical and Health Building. In discussing these exhibits in the New York *Times* on March 5, Surgeon-General Parran said, "I believe that mental hygiene overshadows everything else and deserves a large share of future attention." It would seem to have special significance also when considered in connection with other sections of the fair which have been classified under the heading "Art of Living" and are concerned with adjustment to the "new life" of the "world of tomorrow."

The mental-hygiene exhibit will be a very simple affair, of modest size, and designed to convey the principles and teachings of mental hygiene in a constructive manner and in terms approximating the

average level of understanding. It will be in tune with the other health exhibits, all of which are definitely related to plans for a permanent American Museum of Health which it is hoped will be established in New York after the fair, to be devoted to mass education in health and hygiene. It will occupy 500 square feet of space in the Medical and Health Building, in a choice location near the Theme Center, with its trylon and perisphere. The material of the exhibit will deal exclusively with the preventive and "positive" aspects of mental health and not at all with its pathological side. That phase of the subject will be covered in a separate exhibit set up in the New York State Building by the State Department of Mental Hygiene, which will show the progress made in the treatment and cure of the mentally ill, as exemplified by a progressive state-hospital system with modern standards of care and treatment.

The organization and planning of the mental-hygiene exhibit presented many problems and difficulties, what with the vast scope of the subject and its complex interrelationships, the limitations of space, the intangible and abstract nature of material not readily adapted to visual presentation, the selection of nuclear concepts and their translation into clear, simple, and concrete terms. The need of verbal economy and the difficulty of reducing the great mass of available subject matter to a few simple formulations that would be valid and meaningful as well as easily understood presented the greatest problem. The National Committee for Mental Hygiene, which is sponsoring the exhibit, worked with a special committee appointed by the World's Fair Advisory Committee on Medicine and Public Health to study the matter. This special committee wrestled with the problem for many months, developing and clarifying its ideas, experimenting with various formulas and methods of approach, studying form and content, and finally bringing in a practical plan calculated to achieve the creation of a suitable exhibit. The technical and artistic problems were solved, very successfully we believe, by an expert in exhibit designing engaged by the committee.

The exhibit will be a novel one in many respects and quite different from the conventional chart-and-statistic form of exhibit. It will be mainly a three-dimensional affair, with moving devices and mechanical demonstrations, in the contriving of which the designer drew freely on his fertile imagination. The emphasis throughout is on the personal application of mental-health principles and practices; the message in every instance is aimed at the individual and is intended to show how the discoveries and teaching of mental hygiene affect his own life and activity. It does not attempt to tell the whole story, nor will it convey anything

new to the student familiar with the subject. It is rather an introduction to the subject for the benefit of the uninitiated, a primer in gadget form through which to convey a few elementary, but fundamental lessons in mental hygiene. As such it must have cogency, appeal, force, and directness, and we believe the exhibit as conceived and planned will meet these specifications. The design and arrangement, in line and form, are in the modern manner. The color scheme is brilliant and the balance is such as to attract attention both to individual items of the exhibit and to its total aspect. We hope it will win the attention of the greater part of the fifty million visitors expected at the fair and thus establish a wider contact between the mental-hygiene movement and the public.

Here we can give only a sketchy idea of the content of the exhibit. On the farther wall, opposite the entrance, as a sort of backdrop to the exhibit, will be painted a large mural showing in the upper part examples of success, happiness, efficiency, good adjustment, mental and emotional health, illustrated by appropriate figures. Paralleling these, will be other figures illustrating, in contrasting colors, conditions of failure, inadequacy, frustration, unhappiness, and maladjustment in its various forms and degrees. In between are shown symbolically the various types of mental-health agencies to which recourse can be had for advice and help in transforming those in the unfortunate lower group into the status of the more fortunate higher group. Lines of reference will connect the figures in each group with the appropriate agency symbols.

At various points on the floor, suitably spaced, will be set up various devices of different shapes and sizes graphically presenting mental-health ideas in one form or another. For example, one piece of apparatus, with frosted glass, will contrast the physically crippled with the mentally crippled. A picture of a healthy child is flashed on the glass, with a caption reading "You would not blind your child." Then this figure turns into a silhouette and a picture of a blind child appears and a new caption reads, "But you blind his mind when with too much praise you blind him to his limitations, or with too much blame you blind him to his abilities, or when you give him false information about sex." The scene then changes to another series of pictures under the caption, "You would not poison your child," with contrasting statements, and so on.

A second contrivance is the "Question Box" presenting a disklike surface on which are flashed, in consecutive order, a series of the questions more commonly asked in the field of mental health, together with authoritative answers.

Then there is the distortion mirror, designed to symbolize the

concept of insight or "seeing ourselves as we are." Attached to this is a dial, which may be turned to any one of five positions in which one sees one's self reflected as a superior, well-adjusted, or average personality, or as an inadequate, unstable, or disordered personality, as the case may be.

Another, more complicated mechanism is a machine illustrating the concept of balance in relation to mental life. From one end of the balancing arm are suspended the various theoretic forces that enter into personality and character make-up, representing, for example, love, hate, fear, rage, and other similar or contrasting emotions. From the other end is suspended the figure of a man who moves over an undulating surface on which are depicted various life situations and difficulties which confront him at one time or another, his adjustment or lack of adjustment to which indicates a balance or lack of balance of the forces of personality.

Another display will be an illuminated, moving ribbon of type carrying short, crisp statements which convey pithy mental-health messages. Indeed, all of the exhibit captions will be of this character —brief, pointed phrases and sentences that will not take long to catch the eye, that will merely carry suggestive ideas and will register in the mind of the spectator sufficiently, we hope, to stimulate his interest and impart some notion of the significance and importance and meaning of mental health and hygiene. Psychiatric social workers, to be provided through the courtesy of the New York State Department of Mental Hygiene, will be in attendance at the exhibit to guide the visitors, answer questions and otherwise assist in making it an effective educational venture. A limited amount of specially selected printed matter will be available at the exhibit for free distribution, and visitors will be directed to the various mental-health agencies and allied sources for further information.

The National Committee had the benefit of the advice of a large group of distinguished psychiatrists, but a small committee—composed of Dr. Frederick W. Parsons, Chairman, Dr. Ira S. Wile, Mrs. Henry Ittleson, Dr. David Levy, Dr. Karl M. Bowman, and Dr. James S. Plant—is responsible for translating into an exhibit the views of the larger group. Mr. H. Edmund Bullis of the National Committee served as secretary to the smaller, active group.

We are especially under deep obligation to Mrs. Henry Ittleson who, with her friends, provided the funds to defray the expense of preparing the exhibit, and whose vision and enterprise and faith in mental hygiene made it possible to undertake the project. And we congratulate Mr. Russell Wright and his associates on their ingenious achievement in designing and working out the technical and artistic details of the exhibit and thank them for their fine coöperation with

the committee in translating their ideas into such attractive and satisfactory visual forms.

Sixteenth Annual Meeting of the American Orthopsychiatric Association

The American Orthopsychiatric Association held its Sixteenth Annual Meeting in New York City, on February 23–25, under the presidency of Dr. Frank J. O'Brien, Director of the Bureau of Child Guidance of the New York public schools. Over a thousand members and guests of the Association filled the ballrooms of the Commodore Hotel where the sessions were held. Alert to trends of the times, and cognizant of the psychological implications of current events as they affect man's struggle to adjust to the modern world, the Association arranged an intriguing and varied program dealing with vital problems of the day and showing again the wide scope and catholicity of its interests.

The scientific papers and discussions concerned themselves with many aspects of human behavior, normal and abnormal, and presented much new material of considerable public as well as professional interest. A feature of the program, which is usually focused on problems of childhood and youth, was the symposium on old age and aging, which the various social-security movements have made a "topic of the times." For thousands of years hardly one-twentieth of the population was over sixty. To-day one out of ten persons is past sixty, and ten years hence, it is estimated, one-seventh of our people will be at that age. The speakers speculated on what the needs of this "new race of mankind" might be, beyond the more obvious ones of economic security and medical care. They anticipated that representatives of government, industry, and welfare will soon be looking for expert advice in matters concerning the changes in mental states, emotional reactions, and social adjustments that occur to men and women during later maturity and old age. With little experimental or clinical evidence to guide the experts in considering these issues, the discussants contemplated the need of new techniques and procedures toward the development of a valid science of "geriatrics," the new specialty dealing with the study of senescence.

Another feature was a discussion of the importance of mental hygiene to industry, in which the business executive was urged to consider human as well as economic motives in adjusting the worker to his job, and to regard "the total personality in the total situation." Other papers presented an anthropological and cultural study of hostility in Pilaga Indian children; psychoanalytic theories of the

learning process; the relation of capital crimes to adolescent conflict; a clinical study of child arsonists; trends in therapy and training; and other topics appealing to the interests of workers in child guidance.

An entire session on the last day of the conference was devoted to the field of education and the influences of the teacher's function on emotional growth. In this session, Dr. Carson Ryan defined the broadening concept of the educational philosophy that is slowly percolating through the general-school systems. That philosophy, he said, is based on the premise that education is not a mere acquisition of knowledge, but the application of knowledge by human beings for the benefit of society as well as for themselves; and for that philosophy "our teachers must be freshly equipped." Mrs. Elizabeth Healy Ross evaluated progressive education, tracing its development from the early days—when curricular organization, with its emphasis on "self-expression," was centered exclusively on the interests of the child, and responsibility for direction and standards in behavior and learning was ignored—down to the present, when the pendulum is swinging the other way and the values of group life are being stressed.

Dr. O'Brien, in his presidential address on "Mental Hygiene and Education," also reviewed the changing philosophical implications of progressive education in recent years, chiding those who accepted the child's interests "as the guiding star of all educational efforts," and those in another camp who hold "that educators should be interested primarily in the social order" and who would "draw up Utopian blueprints" to change the existing order. In contrast to these, Dr. O'Brien pointed out, are the leaders in modern educational advance who are fully aware of the limitations of the traditional school, but equally appreciative of its contributions; who believe that the three R's have a place in any educational program and that the problems that beset the formulation of a more effective type of education will be solved, not by omitting the practices of the old school, but putting them in their proper relationships to other educational instruments. They realize, moreover, that the change in educational philosophy from the three R's as its objective to that of the total personality of the individual child is too far-reaching in its implications to be accomplished by the mere modification or expansion of pedagogical goals and practices. "Accepting the personality of the child as the responsibility of education," Dr. O'Brien said, "requires the use of knowledge and procedures that are characteristic of the clinical professions in the broad sense, as compared with pedagogy in the narrow sense. Neglecting to recognize this fact and attempting only to modify and adapt the

existing pedagogical procedures to the new educational objectives, contributed also to the difficulties and lack of success that characterized many of the earlier efforts to develop a more effective type of education."

Dr. Samuel W. Hartwell of Buffalo, N. Y., was elected president of the Association for the new year, and E. K. Wickman, of New York City, vice-president. Dr. Norvelle C. LeMar and Dr. George S. Stevenson, both of New York, were reëlected secretary and treasurer, respectively. The next annual meeting of the Association will be held in Boston.

Dr. Donald Gregg

In the death of Dr. Donald Gregg, The National Committee for Mental Hygiene has lost one of its most valued and respected members. He was one of that company of physicians, distinguished in the practice of their specialty, but with interests as broad as medicine, whose large understanding and active support of mental-health aims have been an unfailing source of strength and encouragement to the movement and its sound development and growth. His thorough training and wide experience in general medicine as well as in psychiatry ideally fitted him for his work with the individual patient and for the larger activities of mental hygiene with which he identified himself early in his splendid professional career.

Dr. Gregg's interest in organized mental-health work dates back to 1913, when, after a period of service as house officer of the Boston Psychopathic Hospital, he joined the Massachusetts Society for Mental Hygiene, serving successively as a director, as a member of the executive committee, as assistant treasurer, vice-president, and president of the Society. The last office he held for five years, up to the time of his death. He thus took his place in a long line of leaders who were responsible for the work which that organization has carried on with such distinction for many years, to the benefit of the country as well as the Commonwealth of Massachusetts.

Dr. Frank Norbury

It is with deep regret that we record the passing of Dr. Frank P. Norbury, who served as Acting Medical Director of our National Committee during the World War. Although he lived longer than most of his contemporaries and achieved the enviable distinction of completing fifty years of distinguished service in his profession, the celebration of which was a source of great satisfaction to us a year ago, we are nonetheless grieved at his going and deeply sensible of the loss of another of our old psychiatric friends. Dr. Norbury was one of the early pioneers in psychiatry and mental hygiene who

laid the foundations for the great progress and development of this field in recent years, to which he so richly contributed throughout his long and eminent career.

We of the National Committee feel especially indebted to Dr. Norbury for his invaluable services during the war, when he carried the responsibility for the administrative direction of the organization on the civilian side of its work, while, at the same time, assisting effectively in its war-work activities. Those of us associated with him during this period remember him affectionately for his attractive professional and personal qualities, his executive ability, and his superior capacity for understanding and getting along with people. He was every inch the physician and gentleman.

"Psychosomatic Medicine"

Under this title, with *Experimental and Clinical Studies* as its subtitle, a new journal, the first issue of which appeared in January, takes its place among the growing number of medical periodicals. It is published quarterly, under the sponsorship of the Committee on Problems of Neurotic Behavior, Division of Anthropology and Psychology of the National Research Council, with financial aid from the Josiah Macy Jr. Foundation. Its aim is to "bring together studies which make a contribution to the understanding of the organism as a whole . . . materials now usually separated widely in manner and place of publication because of differences in concept, approach and methods." The title, *Psychosomatic Medicine*, signifies the newer tendencies in medical thinking—the attempt to erase the distinction between body and mind in the study of human biology and to unify the physical and the mental in a true fusion of the scientific disciplines now concerned with one or the other aspect of the person. In using the term "psychosomatic," the editor explains, "no dichotomy is implied, but instead the correction of a dichotomy. Our understanding of disease rests on pictures taken from these two angles viewed simultaneously, and correlated. When medicine has apprehended the psychosomatic problem and assimilated it, all medicine will be psychosomatic and the adjective redundant." The managing editor is Dr. Flanders Dunbar, 2 East 103rd Street, New York City.

Back Copy of "Mental Hygiene" Wanted

A request has come in for a copy of the April, 1930, issue of Mental Hygiene, the International Congress number. If any reader has a copy of this issue that he does not care to keep, we would appreciate it if he would send it to The National Committee for Mental Hygiene, 50 West 50th Street, New York City.

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